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No. _____ OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

GENERAL AMERICAN LIFE INSURANCE COMPANY,
Petitioner,

v.

IT CORPORATION, *et al.*,
Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether, contrary to the holdings of seven other circuits, the Ninth Circuit correctly held that a contract service-provider is a "fiduciary" under the Employee Retirement Income Security Act of 1974 ("ERISA") when it merely performs initial claims-handling and check-writing services for an employee benefit plan under a framework of rules established by the plan's administrator.

2. Whether, contrary to the plain language of ERISA and the law in other circuits, the Ninth Circuit correctly held that a contract service-provider automatically becomes an ERISA "fiduciary" whenever it handles plan money or has check-writing authority to pay benefits.

PARTIES

The petitioner is General American Life Insurance Company ("General American"). The respondents are IT Corporation, IT Corporation Benefit Plan, and Harry Joseph Lukowski.

Pursuant to Rule 29.6 of the Rules of the Supreme Court, petitioner states that GenAmerica Corporation is the parent of General American, and that General American Mutual Holding Company is the parent of GenAmerica Corporation. General American has the following subsidiary (other than wholly owned subsidiaries): Reinsurance Group of America, Incorporated.

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

Petitioner General American Life Insurance Company ("General American") respectfully submits that a writ of certiorari should issue to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals is reported at 107 F.3d 1415, and is reprinted in the Appendix hereto as 1a to 12a. The court's denial of General American's petition for rehearing, with a suggestion for rehearing en banc, App. 17a, is unreported. The district court's opinion (App. 13a to 16a) is unreported.

JURISDICTION

The court of appeals' opinion was filed on March 7, 1997. A timely petition for rehearing, with a suggestion for rehearing en banc, was denied on June 23, 1997. This petition is being timely filed within 90 days of that denial. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

This case involves §§ 3(21)(A), 402(a)(1), (b)(2), 405(c)(1), 412(a) and 503 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §§ 1002(21)(A), 1102(a)(1), (b)(2), 1105 (c)(1), 1112(a) and 1133, and 29 C.F.R. §§ 2509.75-8 (D-2, D-3), 2560.503-1, and 2580.412-4 and -6. The pertinent text of these statutes and regulations is set forth in the Appendix at 33a to 51a.

STATEMENT OF THE CASE

A. Factual Background

Respondent IT Corporation ("IT Corp.") sponsored a self-funded health care plan (the "Plan"). IT Corp. was

the "named" fiduciary, serving as Plan Administrator and ERISA claims review fiduciary. The Plan identified IT Corp. as the "Plan Administrator," stating that it "shall have the authority to construe and interpret the terms of the Plan, and resolve any disputes which may arise . . . including but not limited to eligibility for participation and claims for benefits." App. at 23a. Respondent Lukowski was a plan participant.

General American served as a third-party administrator for IT Corp. pursuant to an Administrative Services Agreement ("ASA") between the two companies. App. at 25a to 32a. The Plan and ASA did not delegate any fiduciary duty to General American, nor any power to construe or interpret the Plan.

The ASA required General American to perform various administrative tasks for IT Corp. which included verifying eligibility for coverage, preparing benefit checks, and sending them to IT Corp. for distribution. The ASA specified that General American was to perform its duties as "agent" of IT Corp.; that it was to "maintain Blanket Bond Coverage"; that it had "no power or authority" to act for IT Corp. other than as expressly granted in the ASA, or to "alter, modify, or waive" any of the Plan's terms and conditions; that it should consult with IT Corp. in claim matters that were beyond the ordinary; and that "[a]ll contested or doubtful claims' were to be referred to IT Corp. for its determination. Under the ASA, any claims "involved in legal action" should be turned over to IT Corp.; likewise, legal action to recover payments to or on behalf of ineligible individuals was left to IT Corp. Further, the ASA specified that General American "perform[ed] purely ministerial functions for [IT Corp.] within a framework of policies, interpretations, rules, practices and procedures made by [IT Corp.]," and that it should not "be considered the named fiduciary under the Plan." App. at 25a to 30a.

The ASA also stated that General American should use reasonable care and diligence in performing its duties for

IT Corp. Under the ASA's cross-indemnification agreements, General American agreed to indemnify IT Corp. for any loss, damages, and expenses resulting from dishonest, fraudulent, criminal acts, or acts of gross negligence by General American. In turn, IT Corp. agreed to indemnify General American for all loss, damage, and expense resulting from claims, demands or lawsuits brought against it in connection with its services, *except* any dishonest, fraudulent or criminal acts, or acts of gross negligence by General American. App. at 27a.

B. The Complaint

The district court complaint, filed by IT Corp., the Plan, and Mr. Lukowski, attempted to allege a single claim against General American for "breach of fiduciary duty" under ERISA. App. at 18a to 21a. After alleging in conclusory terms that General American was a "fiduciary," it averred that General American "failed to verify the eligibility" of a participant's child to participate in the Plan; that the child was too sick to meet the Plan's "late enrollee" requirement that he be "able to carry on the duties and activities of a person of similar age"; and that General American paid a substantial amount of uncovered claims—more than $600,000—allegedly with "plan assets" "in violation of the terms of [the] Plan, and of the [ASA]." App. at 19a to 20a.

C. The District Court's Decision

The district court, in a decision by Judge Stephen V. Wilson, treated General American's Rule 12(b)(6) motion to dismiss the complaint, in essence, as one for summary judgment, and granted it on the ground that General American was not a fiduciary under § 3(21)(A) of ERISA, 29 U.S.C. § 1002(21)(A). The district court's jurisdiction was based upon §§ 502(a)(2) and (e)(1) of ERISA, 29 U.S.C. §§ 1132(a)(2) and (e)(1). Gen-

eral American has not contended that it is immune from any suit under ERISA.[1]

Rejecting IT Corp.'s argument that General American was a "fiduciary," the district court relied on *Kyle Railways v. Pacific Admin. Services, Inc.*, 990 F.2d 513 (9th Cir. 1993). App. at 13a to 16a. In *Kyle*, the Ninth Circuit, like every other circuit to have considered the issue, held that a contract service-provider merely engaged in initial claims-handling and payment under plan rules is not an ERISA fiduciary. *Id.* at 516. In *Kyle*, as in the present case, the plan vested all discretionary authority in the employer; moreover, the ASA in *Kyle* required the service-provider to refer to the employer all discretionary claim questions. The *Kyle* employer sued it for breach of fiduciary duty in allegedly "exercis[ing] discretion not conferred" by the ASA and "paying claims not covered under the plan." *Id.* at 515-16. *Kyle* ruled that the service-provider's "alleged negligence in following the Plan does not change the fact that [it] was still obligated to *follow* the Plan and that [the *employer*] retained ultimate responsibility . . . for all claims." *Id.* at 516 (emphasis added). The Ninth Circuit held that the service-provider was not

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[1] General American believes that IT Corp., as Plan Administrator, is not without relief. IT Corp. can sue General American as a non-fiduciary for equitable relief to enforce the ASA's cross-indemnity provision which benefits both it and the Plan, if it truly thinks that benefits were paid without its approval. Section 502(a)(3) of ERISA authorizes a suit by a fiduciary to obtain "appropriate equitable relief . . . to enforce . . . the terms of the plan." ERISA's "written plan instrument" rule, which is one of ERISA's "core functional requirements," *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995), and which sets it apart from the law of trusts, requires that all plans be in writing, and be administered by their fiduciaries "in accordance with the documents and instruments governing the plan," §§ 402(a), 404(a)(1)(d). These written instruments plainly include the ASA as a "contract, or other instrument under which the plan is . . . operated," § 104(a)(1), (b)(4). It would be anomalous to conclude that the same Congress which *required* all plans be in writing, and *required* all fiduciaries to enforce their written terms, did not also intend § 502(a)(3) to provides the necessary civil enforcement mechanism.

given any discretionary authority by the employer under the ASA and therefore was not a "fiduciary." *Id.*

D. The Ninth Circuit Decision

The Ninth Circuit reversed the decision of the district court and ordered a remand. It began by observing that "fiduciary" status is determined based on what a party's duties are, not on how they are characterized in a contractual document, and that § 410(a) of ERISA, 29 U.S.C. § 1110(a), forbids any exculpatory provision which purports to relieve a fiduciary from fiduciary liability. App. at 4a to 5a. It failed to note, however, that ERISA allows an *employer* to agree to indemnify a fiduciary. 29 C.F.R. § 2509.75-4 ("Indemnification provisions which leave the fiduciary . . . liable but merely permit another party to satisfy [such] liability . . . are . . . not void under § 410(a)").

On the merits, the Ninth Circuit first held that although General American was *not* a "named fiduciary" (such as a plan administrator (§ 3(16)(A) of ERISA, 29 U.S.C. § 1002(16)(A)), it would be an "unnamed" fiduciary if its decisions about claims involved plan interpretation and judgment. It ruled that ERISA fiduciary functions under § 3(21)(A) of ERISA, 29 U.S.C. § 1002(21)(A), would include any decision by General American on claims, apart from simply typing a treatment code number and treatment provider identification onto a computer screen for generation of a payment check, or a simple mathematical computation of benefits. It concluded, in essence, that any claims-handling work in the area of verifying eligibility for participation or benefits or any application of plan procedures would involve plan interpretation and *judgment* and thus create fiduciary status. App. a 5a to 10a. Second, the court held that General American's handling of "plan assets" or power to write checks in applying the plan's eligibility rules was authority or control over management of the plan or disposition of its assets within the meaning of § 3(21)(A), and thus automatically made it a fiduciary on that ground as well. App. at 10a to 12a.

The decision, by its own terms, applies across-the-board to all contract service-providers, including third-party administrators, commercial insurers, and claims agents, regardless of whether the decision is to approve or deny a claim, and to all persons who handle plan assets or have the power to write checks in acordance with the plan's rules. This would include even the plan sponsor's own employees if they engage in initial claims-processing and payment for a self-funded plan, as well as employees of Taft-Hartley trust funds. The decision thus touches *all* employee benefit plans.

REASONS FOR GRANTING THE WRIT

The Ninth Circuit's decision not only affects all employee benefit plans, but it falls in an area of ERISA fiduciary law involving an extraordinary volume of recent reported decisions nationwide. The decision creates a highly-significant conflict with the law of the seven other circuits which have considered the issue of fiduciary status of contract service-providers under § 3(21)(A) of ERISA, 29 U.S.C. § 1002(21)(A). This will create especially acute problems for plans that operate on a multi-state basis. The decision also creates a needless dissonance between three central parts of the statute dealing with fiduciaries: § 3(21)(A); § 503, 29 U.S.C. § 1133 (the fiduciary claims review section); and § 412(a), 29 U.S.C. § 1112(a) (the plan assets and bonding section). In addition, it conflicts with the questions and answers and regulations of the Department of Labor, the federal agency charged with the interpretation and enforcement of ERISA pursuant to §§ 505 and 504, 29 U.S.C. §§ 1135, 1134. The Department's questions and answers and regulations brilliantly harmonize these three statutory sections. Its construction of ERISA, moreover, is entitled to considerable weight. *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-45 (1984).

The decision errs on two very siginficant, recurring issues of statutory construction involving ERISA fiduciary status under § 3(21)(A). First, it held that a contract

service-provider merely performing initial claims-handling and payment under plan eligibility rules is an ERISA "fiduciary" despite the employer's retention of authority over plan interpretation and disputes involving eligibility, such retention being a common plan characteristic. Second, it held that a party becomes an ERISA "fiduciary" automatically by reason of the handling of plan money or check-writing authority under the plan's rules.

1. ***A Contract Service-Provider Does Not Become a "Fiduciary" Merely by Engaging in Initial Claims-Processing and Payment Under Plan Rules.***

By holding that an archetypal contract service-provider is a "fiduciary" if it merely performs day-to-day, initial claims-handling and payment, including the application of plan eligibility rules, the Ninth Circuit's decision conflicts with the rule followed by seven other circuits. It also conflicts with the Department of Labor's 1975 "safe-harbor" questions and answers on fiduciary responsibility in 29 C.F.R. § 2509.75-8(D-2, 3), on which the court purported to rely; its 1977 initial claims-handling and review of denied claims regulations in § 2560.503-1; § 503 of ERISA, which describes the ERISA claims review fiduciary; the plan asset and bonding rules in § 412(a), which make a clear distinction between "[e]very fiduciary of an employee benefit plan," and "every person who handles funds or other property of such a plan" ("plan officials"), who must be bonded; and the bonding regulations in 29 C.F.R. § 2580.412-4 and -6.

The questions and answers clarify the definition of "fiduciary" by allowing a contract service-provider to know in advance that it has a broad "safe-harbor" from fiduciary status if it merely performs "administrative" and "purely ministerial functions," such as "[*a*]*pplication* of rules determining eligibility for participation or benefits," "[c]alculation of benefits," and "[m]aking recommendations to others for decisions with respect to plan administration," under a "framework of . . . rules . . ." established by another party. (Emphasis added). In the "safe-harbor," the

Department of Labor accurately summarized in 11 broad categories the typical functions of contract service-providers, clarifying that these business activities will be non-fiduciary as long as they are performed under the plan's existing rules. The decision effectively destroys the intentionally broad shelter of the "safe-harbor" because every service-provider is required to make decisions, and uses some judgment and discretion, in applying the plan's eligibility rules or making recommendations on plan administration. The decision thus works at counter-purpose to the "safe harbor," pushing the notion of "fiduciary" status so excessively that it picks up parties who merely perform administrative and ministerial tasks under plan rules. "Having to make a decision in the exercise of a ministerial duty does not rise to the level of discretion required to be an ERISA fiduciary." *Arizona State Carpenters Pension Trust Fund v. Citibank (Arizona)*, —— F.3d ——, —— (9th Cir. 1997), 1997 U.S. App. LEXIS 23587, *15.

The decision also disrupts a consistent, long-standing, common-sense interpretation of § 3(21)(A) by seven other circuits and the Department of Labor, one which carefully reconciles the statutory definition of fiduciary, the fiduciary claims review section, and the plan assets and bonding provisions. Innumerable employee benefit plans and contract service-providers use this "safe-harbor" in order to secure experienced and efficient plan administration. Within this framework and the procedures set out in the plans, the service-providers can assist the employers without having to get each action ratified. If this "safe-harbor" were not available, each employer would be forced to administer its own plan with its own employees, with a consequent loss in employee medical records privacy and claims-handling efficiency and expertise. The "safe-harbor" also provides "bright line" distinctions which strongly assist not only the advance-planning by employers and service-providers, but also the interest in judicial economy, as shown in its embrace by seven other circuits.

Additionally, the decision will also make it very difficult, if not impossible, for many plans to continue using cost-effective, experienced third-party administrators or other outside claims-handling agents, including Blue Cross/Blue Shield organizations. As accurately summarized in F.A. BRODIE & J.D. GATTER, "When Are Claims Administrators ERISA Fiduciaries," PENSION & BENEFITS WEEK 7 (June 9, 1997), under the Ninth Circuit's decision "a claims administrator may avoid ERISA fiduciary liability only by declining to exercise *any* discretion in administering the plan—*a severe restriction of the service provider's function that may be unacceptable to plan sponsors*" (emphasis added). All of this conflict and litigation over an issue of "fiduciary" status already decided by the "safe-harbor" rule will increase plan transaction and litigation costs which, in turn, will ultimately require employers to reduce benefits or possibly even eliminate them altogether. *See Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 13 (1987). This will cut across the grain of the "strong public interest in encouraging the formation . . . of employee benefit plans," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

2. *A Party Does Not Become a "Fiduciary" Automatically by Handling Plan Money and Having Check-Writing Authority.*

By holding that a party which handles plan money or has check-writing authority to pay benefits under the plan's terms automatically becomes a "fiduciary," the Ninth Circuit's decision once again touches every employee benefit plan but fails to read the ERISA statute as a whole. The decision is directly contrary to the plain language of the ERISA section governing the handling of plan assets and bonding. Section 412(a) of ERISA, 29 U.S.C. § 1112(a), which the court ignored, carves a clear-cut distinction between (1) "[e]very fiduciary of an employee benefit plan," and (2) "every person who handles funds or other property of such a plan" (termed by statute "plan officials"), who are subject to bonding requirements but are not fidu-

ciaries. The Department of Labor's bonding regulations track this statutory distinction and include, as "plan officials," individuals who pay claims and have check-writing authority over plan assets, and who are in a position to cause loss to a plan through fraud or dishonesty. 29 C.F.R. § 2580.412-4 and -6. In addition, the 1975 questions and answers explain that while an individual engaged in initial claims-processing may be "subject to [ERISA's] bonding requirements" if it handles funds or other property of the plan," it is *not* a "plan fiduciary" if it performs the ministerial duties specified therein. § 2509.75-8(D-2). The decision also conflicts with the law in other circuits, discussed below. Furthermore, the legal situation envisioned by the Ninth Circuit was not even within the realm of possibilities allowed by ERISA. The statutory sections governing the allocation of fiduciary responsibility not only require that any allocations be contained in the written plan instrument, but forbid a "named" fiduciary, such as IT Corp., from delegating to anyone other than an investment manager the authority or discretion to manage or control plan assets. §§ 402(a)(1), 405(c)(1) of ERISA; 29 C.F.R. § 2509.75-8(FR-15); D. BACON, S. PRATER, D. TUCKER, EMPLOYEE BENEFITS GUIDE § 7.04[6] (Matthew Bender & Co. 1996).

3. *The Ninth Circuit's Decision Will Have Significant Adverse Impacts on Plans.*

The Ninth Circuit's decision not only clashes with the overall structure and logic of the statute and its regulations, but throws concepts of administrative agency expertise and judicial economy to the winds. In addition, it will encourage forum shopping especially in the case of large national plans. In particular, suits in which a plaintiff seeks a fiduciary remedy against a contract service-provider will be brought in the Ninth Circuit. The decision, moreover, will engender major confusion across the country for employers small and large, especially for those with nationwide operations. It will adversely impact not only all parties providing administrative services for ERISA plans,

most of which have the initial claims-handling and payment done by someone *other* than the plan sponsor, but also countless bonded "plan officials" and Taft-Hartley trust employees who handle plan assets or have check-writing authority. For example, over 159 million individuals are covered by private sector employer-sponsored health care plans,[2] and for 91% of these plans, some portion of claims-handling and payment is performed for reasons of economy and expertise by parties other than the employers—such as third-party administrators, Blue Cross/Blue Shield plans and commercial insurers.[3] Many of these plans, moreover, are multi-state in operation. This Court's review is necessary to resolve the conflict among the circuits on the important, recurring issues of whether ERISA's definition of "fiduciary" encompasses service-providers merely performing initial claims-handling and payment pursuant to plan rules, and bonded "plans officials" who handle plan assets or have check-writing authority within those rules.

I. THE NINTH CIRCUIT'S DECISION THAT A PARTY MERELY PERFORMING INITIAL CLAIMS-PROCESSING AND PAYMENT IS A FIDUCIARY SHARPLY DEPARTS FROM THE CORRECT, COMMON-SENSE RULE FOLLOWED BY SEVEN OTHER CIRCUITS.

A. The Court Below Incorrectly Imposed Fiduciary Status on Parties Merely Engaged in Administrative, Ministerial Claims Activities.

Until the Ninth Circuit's recent decision, it was well-settled that the business of initial claims-handling and payment for an ERISA plan—as distinguished from the fiduciary review procedure for denied claims—was *not* an ERISA fiduciary function. *See* § 503 of ERISA, 29 U.S.C. § 1133 (the only ERISA section imposing fiduciary duties

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[2] STATISTICAL ABSTRACT OF THE UNITED STATES, p. 120 (116th ed. 1996).

[3] 1996 FOSTER HIGGINS NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS, 18-19 ("FOSTER HIGGINS SURVEY").

in the claims area, but doing so solely with respect to a party designated by the plan to conduct the ERISA review procedure for *denied* claims); *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 143-44 (1985) (carefully observing that ERISA's "FIDUCIARY RESPONSIBILITY" provisions are contained in Part 4 of Title 1 of ERISA, whereas the claims provisions are contained in Part 5, "ADMINISTRATION AND ENFORCEMENT," with fiduciary responsibility for claims set forth in § 503 dealing with the review of "*denied*" claims). Similarly, the Department of Labor's 1975 questions and answers state that in contrast to "functions described in section 3(21)(A) of the Act," specified initial claims-processing functions, including "[a]pplication of rules determining eligibility for participation or benefits," are "administrative" and "purely ministerial" functions *outside of fiduciary status* if performed within a framework of rules established by another party. 29 C.F.R. § 2509.75-8(D-2). The Department's 1977 claims regulations likewise distinguish between initial claims-processing and payment, which are *non-fiduciary* in nature, and the fiduciary review procedure for *denied* claims. § 2560.503-1.

In addition, as discussed below, numerous other federal appellate courts, following the Department of Labor's lead, have given a common-sense, consistent interpretation to § 3(21)(A), holding that a broad range of initial claims-processing and check-writing activities is *outside* of ERISA fiduciary status if performed within a framework of plan rules. *See* M.J. CANAN & W.D. MITCHELL, EMPLOYEE FRINGE AND WELFARE BENEFIT PLANS § 2.3 (West Publishing Co. 1996) ("Other circuits have reached similar results" to *Kyle*); S.P. SEROTA, ERISA FIDUCIARY LAW, p. 153 (Bureau of National Affairs 1995) (insurers have been held not to be fiduciaries where their duties were "purely ministerial or where they had some discretion . . . but the ultimate authority . . . lay with the employer or the Named Fiduciary"); R. J. COOKE, ERISA PRACTICE AND PROCEDURE § 6.2 (Shepard's/McGraw Hill 2d Ed.

1996); EMPLOYEE BENEFITS GUIDE, *supra*, § 7.02[4][b], [d].

The Department of Labor's 1975 questions and answers, purportedly relied on by the Ninth Circuit, clarify that ERISA provides a wide "safe-harbor" from fiduciary status for contract service-providers. The questions and answers address those individuals who have no power to decide plan policy but merely perform broad ranges of initial claims-handling and payment activities, including the "[a]pplication of rules determining eligibility for participation or benefits," "[c]alculation of benefits," and "[m]aking recommendations to others for decisions with respect to plan administration," within a "framework of policies, interpretations, rules, practices and procedures made by other[s]." Apart from a straightforward benefit computation, *none* of the activities described by the Department involve something as simple and mechanical as typing a treatment code and provider identification onto a computer screen, a nonfiduciary, non-decision making task referred to by the Ninth Circuit. Instead, all of these activities, which are functions that must be performed for every plan, require the exercise of judgment and discretion in *applying* plan rules or making recommendations on plan administration. The Department properly described these nonfiduciary, everyday claims-handling and payment activities as "administrative" and "purely ministerial functions," carefully distinguishing them from what it referred to as "functions described in section 3(21)(A) of the Act." *Id.* It stated that such a party "is not a fiduciary because [it] does not have discretionary authority or discretionary control respecting management of the plan, [and] does not exercise any authority or control respecting management or disposition of the assets of the plan" within the meaning of § 3(21)(A). *Id.*

The Department of Labor thus acknowledged an important distinction, which eluded the court below, between a person, such as the Plan Administrator, to whom the plan has granted the power to make binding decisions as to *how* it should be interpreted, and contract service-

providers who later merely *apply* the plan's eligibility rules, within the existing framework of policies and interpretations, in determining participation rights and entitlement to benefits. While the latter class of persons may be called upon to exercise judgment and discretion, their decisions are limited to applying the *existing* eligibility rules on a case-by-case basis. Common sense and the questions and answers jointly establish that this type of day-to-day, administrative, purely ministerial decision-making, performed within a framework of plan rules, does not render these persons fiduciaries.

The Department of Labor thus specified for every plan very broad, precisely-defined contours for the initial claims-handling agent's "safe-harbor," enabling parties to gauge accurately, in advance, whether 11 categories of claims and payment activities will be nonfiduciary even though they may require bonding. This "safe-harbor" has allowed employers, Taft-Hartley trust employees, and contract service-providers to predetermine their respective roles and legal responsibilities within the plan's rules. It has also granted them a large measure of protection by allowing them to decline to enter into a contractual arrangement which will produce fiduciary status or to obtain, if necessary, professional or fiduciary liability insurance or appropriate indemnification agreements.

Lastly, as shown above, IT Corp., not General American, was the "named" fiduciary and had the sole "authority to . . . interpret . . . the Plan," serving both as Plan Administrator and ERISA claims review fiduciary. No fiduciary duty was ever delegated to General American, nor any power to interpret or construe the Plan. Furthermore, no dispute over plan interpretation existed in this case, a point established by the complaint itself;[4] there

[4] *None* of the district court pleadings alleged a dispute over plan interpretation. The complaint merely alleged that General American "failed to verify the eligibility" of a child to participate in the Plan. App. at 19a. There was no disagreement as to whether the child met the Plan's "late enrollee" requirement. Even had there been such a disagreement, it would only be a disagreement as to how

was only an alleged failure to verify eligibility. Moreover, this was an alleged failure to perform what the Department of Labor has characterized as a nonfiduciary, "administrative" and "purely ministerial" function outside of the "functions described in § 3(21)(A) of the Act." "[T]he discretionary role needed to support fiduciary status must be more than a *theoretical contrivance.*" *Useden v. Acker*, 947 F.2d 1563, 1574 (11th Cir. 1991) (emphasis added), *cert. denied*, 508 U.S. 959 (1993). Here, there is *not* even a "theoretical contrivance." The *exercise* of fiduciary responsibility is an express requirement for imposing fiduciary liability even on a party which is a fiduciary but is *not* a "named" fiduciary, another key point ignored by the Ninth Circuit. 29 C.F.R. § 2909.75-8 (FR-16) ("a fiduciary . . . who is not a named fiduciary is a fiduciary *only* to the extent that he or she *performs* one or more of the functions described in section 3(21)(A) of the Act") (emphasis added); *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1223, 1325 (9th Cir. 1985) (*per curiam*).

B. The Decision Conflicts With Decisions in All Other Circuits Which Have Considered the Issue.

Demonstrating the significance of the legal issue, at least seven other circuits have recently considered whether a third-party administrator, insurance company, or employer merely performing the business of initial claims-handling and check-writing, and applying the plan's eligibility rules, is a "fiduciary" under § 3(21)(A) of ERISA, 29 U.S.C. § 1002(21)(A). A number of these cases have involved commonplace plan provisions requiring the service-provider to refer disputed claims to the employer, which was given the authority to resolve all disputed claims. While several of these decisions including *Kyle, supra*, have involved a third-party administrator's alleged error in paying uncovered claims, it is well-settled that a person who is not a fiduciary does not become one by

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to *apply* the Plan's rules determining eligibility to a specific fact situation, and thus General American still would not be a fiduciary under the questions and answers.

negligently performing his or her duties, *Kyle, supra*, *Custer v. Sweeney*, 89 F.3d 1156, 1162 (4th Cir. 1996), *Nieto v. Ecker*, 845 F.2d 868, 870-71 (9th Cir. 1988), or even by performing an act outside of those duties, *O'Toole v. Arlington Trust Co.*, 681 F.2d 94, 96-7 (1st Cir. 1982). *All* of the decisions in these seven circuits have rejected fiduciary status.[5] Although the claims-processing and payment agent may require bonding, it is only a fiduciary where it has "authority to resolve all disputes regarding coverage," and is therefore the claims review fiduciary under § 503 of ERISA, 29 U.S.C. § 1133. *Libby-Owens-Ford Co. v. Blue Cross & Blue Shield Mut. Of Ohio*, 982 F.2d 1031, 1032, 1035 (6th Cir.), *cert. denied*, 510 U.S. 819 (1993).

Similar to the district court, all of the circuits which have considered the issue have followed the plain, common-sense meaning of the Department of Labor's 1975 questions and answers and § 503 of ERISA, holding that such parties are *not* fiduciaries under ERISA. *See Santana v. Deluxe Corp.*, 920 F. Supp. 249, 254 (D. Mass. 1996) ("where an employee benefit plan has contracted with a third party to provide claims-processing and other administration services to the plan, but has retained discretion to decide disputed claims, courts have universally ruled that the service provider is not a fiduciary of the plan").

A primary example of this rule is *Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288, 290 (11th Cir. 1989). In *Baker*, the Eleventh Circuit held that an

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[5] The Ninth Circuit itself previously rejected fiduciary status not only in *Kyle, supra*, but also in *Gelardi*, 761 F.2d at 1325 (a third-party administrator was not a fiduciary because it performed "only administrative functions, processing claims within a framework of . . . rules established by others"), and *Gibson v. Prudential Ins. Co. of America*, 915 F.2d 414, 415, 418 (9th Cir. 1990) (an insurer serving as "initial claims-handling agent" was not a fiduciary; it "handled the initial review and investigation of claims, the initial determination of eligibility for benefits under the rules contained in the plan, and the calculation and payment of benefits").

insurance company performing claims services for a self-funded plan was *not* an ERISA fiduciary where it "processed claims and disbursed benefit payments pursuant to the Plan terms under an administrative services agreement with [the employer] which reserved the right to review any and all claims denials." The employer "did no more than 'rent' the [insurer's] claims-processing department." *Id.* at 290. The court explained that the " 'ability to make policy decisions *outside* of a preexisting or separate framework of policies, practices and procedures' determines ERISA fiduciary status" (emphasis added) (citation omitted). *Id.* It held that the insurer did not become a " 'fiduciary' simply by performing administrative functions and claims-processing within a framework of rules established by an employer . . . especially if, as in this case, the claims processor has not been granted the authority to review benefit denials and make the ultimate decisions regarding eligibility." *Id.*

In addition, the Second, Third, Fourth, Sixth, Seventh and Eighth Circuits have held that contract service-providers, insurance companies, or employers merely performing initial claims-handling and payment are *not* ERISA "fiduciaries" where they are required to apply the plan's eligibility rules.

Second Circuit. *Geller v. County Line Auto Sales, Inc.*, 86 F.3d 18, 21 (2d Cir. 1996) (even an employer was not a fiduciary when it improperly verified and guaranteed eligibility of a non-employee to participate in a health and welfare trust, thereby causing a loss to the trust. Under the Department of Labor's questions and answers, "the performance of ministerial functions includes . . . the determination of eligibility for participation or benefits," and a person performing these functions is not a fiduciary). *See also Blatt v. Marshall and Lassman*, 812 F.2d 810, 812 (2d Cir. 1987) (non-fiduciary "ministerial functions include the *application of rules determining eligibility for participation*") (emphasis added).

Third Circuit. *Confer v. Custom Engineering Co.*, 952 F.2d 34, 39 (3d Cir. 1991) (a third-party administrator

"whose responsibilities included . . . handling claims," was not a fiduciary. "[D]iscretionary authority, responsibility or control is a prerequisite to fiduciary status;" "[p]ersons who perform purely ministerial tasks, such as claims-processing and calculation, cannot be fiduciaries because they do not have discretionary roles"; the third-party administrator "had *an obligation to follow the written plan instrument*") (emphasis added).

Fourth Circuit. *HealthSouth Rehabilitation Hosp. v. American Nat. Red Cross*, 101 F.3d 1005, 1007-9 (4th Cir. 1996) (an insurance company which "provides administrative and ministerial services" to an employer's self-funded plan "pursuant to a contract," and has "the authority to make determinations on behalf of [the employer] with respect to benefit payments . . . and to pay out those benefits, subject to [the employer's] reserved right to modify any such determination," was *not* an ERISA fiduciary. "Any discretionary authority over administration of the Plan rested solely with [the employer]"), *cert. denied*, 117 S.Ct. 2432 (1997). *See also Haidle v. Chippenham Hosp., Inc.*, 855 F. Supp. 127, 132-33 (E.D.Va. 1994) (a service-provider was *not* an ERISA fiduciary where the employer delegated to it "authority to make [benefit] determinations on [its] behalf . . . under the Plan and to pay such benefits, subject, however, to a right of [the employer] to review and modify any such determination." The fact that the employer did not review or modify the decisions was not dispositive because *all* that the third-party administrator could do was to *implement* the plan policies).

Sixth Circuit. *Baxter v. C.A. Muer Corp.*, 941 F.2d 451, 452-56 (6th Cir. 1991) (a third-party administrator for a self-funded plan was *not* a fiduciary where it was "merely a claims processor that pays claims in accordance with the terms of the plan," and the plan "reserved to [the employer] the right to construe the plan"; the employer was the Plan Administrator and "named" fiduciary).

Seventh Circuit. *Klosterman v. Western General Management, Inc.*, 32 F.3d 1119, 1124-25 (7th Cir. 1994) (a third-party administrator, as a matter of law, was *not* a fiduciary where it was responsible for "determining eligibility" and making "initial claims determinations" "in accordance with the [plan's] . . . standards," and the employer "retained the authority to make the ultimate decision in all doubtful or contested claims"; "when discretion truly was required, in questionable cases, the ultimate decision belonged to [the employer]"); *Harris Trust and Sav. Bank v. Provident Life and Acc. Ins. Co.*, 57 F.3d 608, 613 (7th Cir. 1995) (same); *Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126, 127-29 (7th Cir. 1992) (a contract service-provider for a self-funded plan performing "the list of ministerial functions spelled out in [the "safe-harbor"] . . . was not a fiduciary." "ERISA makes the existence of discretion a sine qua non of fiduciary duty"). *See also Bromenn Healthcare v. Northwestern Nat. Life Ins. Co.*, 806 F. Supp. 799, 801, 804 (C.D. Ill. 1992) (a third-party administrator which agreed to provide services in accordance with the plan but allegedly overpaid claims was not an ERISA fiduciary; the employer, as Plan Administrator, retained all discretionary authority and control over the plan).

Eighth Circuit. *Kerns v. Benefit Trust Life Ins. Co.*, 992 F.2d 214, 216-17 (8th Cir. 1993) (an insurance company, engaged in the initial processing and payment of claims, was not an ERISA fiduciary; it did "nothing more than perform its normal contractual claims handling function under a group policy." The insurer would be a fiduciary, however, if it were an ERISA claims review fiduciary).

Eleventh Circuit. *Howard v. Parisian, Inc.*, 807 F.2d 1560, 1564 (11th Cir. 1987) (a third-party administrator for a self-funded plan was not a fiduciary where it performed "only claims-processing, investigatory, and record-keeping duties . . . under an independent contract with [the employer]"). *See also Useden*, 947 F.2d at 1574 ("[a]n entity [a lender to an ESOP] which assumes dis-

cretionary authority or control over plan assets will not be considered a fiduciary if that discretion is limited by a preexisting framework of policies, practices and procedures").

Accordingly, this Court should grant certiorari in order to correct the Ninth Circuit's serious statutory construction error and resolve the circuit conflict on the important, recurring issue—indeed, one involving every plan in America—as to whether a party merely performing initial claims-processing and payment under plan rules is a "fiduciary" pursuant to § 3(21)(A) of ERISA.

C. The Decision Ignores a Key Distinction Between Initial Claims-Handling and the Fiduciary Review of Denied Claims—the Only Fiduciary Function in the Claims Area.

The Ninth Circuit's decision as to initial claims-handling and payment under plan rules also ignores a central distinction, for every plan, between nonfiduciary initial claims-processing and payment and the *fiduciary* review procedure for denied claims, which is the only fiduciary function in the claims area. As recognized by the Department of Labor and seven other circuits, the great weight of ERISA's fiduciary responsibility and personal liability provisions in § 409(a), 29 U.S.C. § 1109(a), is *not* triggered by a contract service-provider's merely performing initial claims-handling and payment under a framework of plan rules.

A key part of the Department of Labor's 1975 questions and answers, misread by the court, explains exactly *when* fiduciary status arises in the claims context. The questions and answers specify that the "safe-harbor" is left, and the "fiduciary" sail is raised, when the "*plan* . . . designate[s] as a "*benefit supervisor*" a *plan employee* who has the "*final* authority to authorize or disallow benefit payments in cases where a *dispute exists* as to the *interpretation* of plan provisions relating to eligibility for benefits." 29 C.F.R. § 2509.75-8 (D-3) (emphasis added). This is the only reference in D-3 to a fiduciary role in the claims area. The Department's 1977 claims

regulations establish that the *only* fiduciary claims function is the review procedure for denied claims (§ 2560.503-1); this is in harmony with the earlier questions and answers.

There is a *stark absence* in the questions and answers or regulations of *any* indication that a contract service-provider which merely performs initial claims-processing and payment under plan rules is an ERISA fiduciary. Far to the contrary, the initial claims-processing and payment procedures spelled out in the regulations are all administrative in nature, a point emphasized by the fact that the Department even provided specific time frames and programmed responses for all claims actions. Second, the regulations demonstrate that the plan supervisor with "final authority" referred to in the questions and answers two years earlier is an ERISA claims review fiduciary as defined in § 503 of ERISA, 29 U.S.C. § 1133. Section 503 requires "*every* employee benefit plan" to provide participants with adequate written notice of claim denials, and to "afford a reasonable opportunity . . . for a full and fair review by the *appropriate named fiduciary* of the decision denying the claim" (emphasis added). Similarly, the regulations specify that *every plan* is to "*designate*[ ]" a "named fiduciary" to review and make decisions on claim denials. 29 C.F.R. § 2560.503-1(g). The 1975 questions and answers speak in short-hand terms about the plan's designating a supervisor to have "*final authority*" over disputed claims because *no* regulations had yet been issued on § 503. The questions and answers, however, plainly refer to a supervisory employee, designated by the plan, who would *now* be considered the "named" fiduciary designated by the plan to conduct the review procedure under § 503. Indeed, the only dispute over benefit eligibility could be between a claimant and the plan, and by statute there could be no "final authority" beyond the fiduciary review procedure mandated by § 503.

In summary, all of the other courts of appeals which have addressed this issue acknowledge the critical, common-sense distinction between the nonfiduciary function of merely performing *initial* claims-processing and pay-

ment under plan rules, and the fiduciary review procedure for *denied* claims, a distinction that is carved in the statute (§ 503), the 1975 questions and answers, and the 1977 claims regulations. In addition to creating a circuit conflict, the Ninth Circuit's decision will trigger endless controversy and litigation over what was, and was not, a "fiduciary" function in initial claims-processing and payment, which is exactly the conundrum that the deliberately wide "safe-harbor" was designed to avoid. Further, if as may occur, some employers will be required to take "in house" the claims-processing and payment functions for self-funded plans because contract service-providers raise fees or refuse to serve as fiduciaries, the result will be the loss of employee privacy interests in medical records and a loss of claims-handling efficiency and expertise.

II. THE NINTH CIRCUIT'S DECISION THAT A PARTY WHICH HANDLES PLAN ASSETS OR HAS CHECK-WRITING AUTHORITY AUTOMATICALLY BECOMES A FIDUCIARY CONFLICTS WITH THE PLAIN LANGUAGE OF ERISA AND THE LAW IN OTHER CIRCUITS.

The Ninth Circuit also significantly erred in construing ERISA's definition of "fiduciary" in § 3(21)(A), 29 U.S.C. § 1002(21)(A), so broadly as to automatically include anyone who handles plan money, or has check-writing authority, under the plan's rules, and who may require bonding to protect the plan. Similar to the first issue, this question of statutory construction is an exceptionally important federal issue touching every plan in America, one with a need for national unformity.

The Ninth Circuit cited § 3(21)(A), which states, in part, that a party is a "fiduciary" "to the extent" it "exercises any authority or control respecting management [of a plan] or disposition of its assets." [6] This is *not* the only

[6] In addition, ERISA including § 3(21)(A) and § 415(a) should be read as a whole. The word "discretionary" is used a number of times in § 3(21)(A), and the second of the two phrases in subsection (i), "exercises any authority or control respecting management or disposition of its assets," should be read as *discretionary* "author-

ERISA section which deals with plan assets or fiduciary status, however. Once again, the Ninth Circuit was blind to other pertinent parts of the statute and regulations.

The decision clashes with the plain meaning of ERISA's *specific*, carefully-tailored statutory provision which governs the handling of plan assets and bonding. Section 412(a) of ERISA, 29 U.S.C. § 1112(a), precisely distinguishes between "[e]very fiduciary of an employee benefit plan" and "every person who handles funds or other property of such a plan" and who must be bonded, the latter being termed by statute "plan officials." Not only adhering to the statutory distinction between "fiduciaries" and "plan officials," the Department of Labor's bonding regulations specify that this distinction covers the claims payment area by stating that "funds or other property of such plan" encompass "*all* property which is used or may be used as a source for the *payment of benefits* to plan participants," and include within the bonding requirement "any person with the *power to sign or endorse* checks" (emphasis added). 29 C.F.R. § 2580.412-4 and -6. As indicated, the Department's 1975 questions and answers explain that a party who performs the claims payment tasks outlined in the "safe-harbor," and "*handles funds or other property of the plan*," is "*not* . . . a *plan fiduciary*" but is subject to [ERISA's] *bonding* requirements." § 2509.75-8 (D-2) (emphasis added). The precise language of these statutory and regulatory provisions demon-

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ity or control." In *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140-43 (1985), this Court, in construing § 409(a), held that the last of three phrases, "such other equitable or remedial relief as the court may deem appropriate," should not be divorced from context but must be read as limited to relief "for a plan" notwithstanding that relief for a "plan" was referred to in the first two phrases but not the third. The Court disapproved a "blue pencil" method of statutory interpretation that "impermissibly ignores the relevant context in which statutory language subsists." *Id.* at 141-42. The same is true for § 3(21)(A). As stated by Judge Posner in *Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126, 129 (7th Cir. 1992), "ERISA makes the existence of discretion a sine qua non of fiduciary duty."

strates that Congress did not intend that every person who handles plan funds or has check-writing authority to pay benefits would be a fiduciary.

Furthermore, as indicated above, Congress *forbids* the very situation envisioned by the Ninth Circuit. Under the Plan, IT Corp. as Plan Administrator had the *sole* "authority to control and manage [its] operation and administration," except to the extent that the Plan's written terms allocated fiduciary responsibility to another party (which they did not). § 402(a)(1), (b)(2) of ERISA, 29 U.S.C. § 1102(a)(1), (b)(2). Moreover, ERISA barred the Plan Administrator from allocating any power to "manage or control the assets of the plan" to anyone other than an investment manager. § 405(c)(1), 29 U.S.C. § 1105(c)(1). General American not being an investment manager, and the Plan not allocating such power to it in any event, IT Corp. necessarily retained all discretionary authority to manage or control plan assets. § 405(c)(1) of ERISA; 29 C.F.R. § 2509.75-8 (FR-15); *see also Walker v. National City Bank of Minneapolis*, 18 F.3d 630, 633 (8th Cir. 1994).

The Ninth Circuit's hyper-literal reading of § 3(21)(A) of ERISA, coupled with its complete disregard of §§ 402, 405, 503 and 412(a), not only conflicts with the architecture and logic of the statute and its regulations, but clashes with the law in other circuits. In *Geller v. County Line Auto Sales*, 86 F.3d 18, 21 (2d Cir. 1996), the court held that even an employer (which ordinarily would be a fiduciary almost automatically) that improperly verified and guaranteed eligibility of a non-employee to participate in a health and welfare trust, thereby causing a loss to the trust, was not a fiduciary. Similarly, in *HealthSouth Rehabilitation Hosp. v. American Nat. Red Cross*, 101 F.3d 1005, 1007, 1009 (4th Cir. 1996), the court held that an insurance company was not a fiduciary where it "provide[d] —administrative and ministerial services" and paid benefits "pursuant to a contract" but was

"subject to [the employer's] reserved right to modify any [benefit] determination." [7]

This Court recently pointed out that even the *broadest* sections of ERISA cannot be read with "*uncritical literalism.*" *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1996) (construing the preemption clause in § 514(a), 29 U.S.C. § 1144(a)) (emphasis added). Instead, it held that the *entire* statute must be read logically and as a whole. *Id.*; *see also Crandon v. U.S.*, 494 U.S. 152, 158 (1990). The same is true here: § 3(21)(A) cannot be read without §§ 402, 405, 503 or 412(a), which is exactly what the Ninth Circuit did. In *Nieto v. Ecker*, 845 F.2d 868, 870-71 (9th Cir. 1988), Judge Kozinski correctly observed that ERISA's definition of "fiduciary" could *not* be read in an unduly literal manner to include *anyone* who had authority or control over plan assets. If the rule were otherwise, he wrote, "anyone performing services for an ERISA plan, be it an attorney, an accountant, a security guard or a janitor—would be rendered a fiduciary insofar as he exercised some control over trust assets and through negligence or dishonesty jeopardized those assets." *Id.* The Eleventh Circuit reached exactly the same common-sense conclusion in *Useden v. Acker*, 947 F.2d 1563, 1574 (11th Cir. 1991) (a lender to an ESOP is not an ERISA fiduciary despite its right to dispose of the stock pledged as collateral), *cert. denied*, 508 U.S. 959 (1993); *see also Chapman v. Klemick*, 3 F.3d 1508 (11th Cir. 1993) (an attorney who handled settlement proceeds which were plan assets was not an ERISA fiduciary). Judge Kozinski and the Eleventh Circuit were manifestly correct in not applying an illogical or overly literal interpretation to § 3(21)(A), which is only *one* of ERISA's provisions dealing with plan assets and fiduciaries.

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[7] *See also Baxter v. C.A. Muer Corp.*, 941 F.2d 451, 452-56 (6th Cir. 1991); *Baker v. Big Star Division of the Grand Union Co.*, 893 F.2d 288, 290 (11th Cir. 1990); *Confer v. Custom Eng'g Co.*, 952 F.2d 34, 39 (3d Cir. 1991).

In sum, as a matter of statutory construction the Ninth Circuit could *not* focus solely on § 3(21)(A) and ignore §§ 402, 405, 503 and 412(a), the bonding regulations or key provisions in the questions and answers, on the ground that they dictated a result contrary to the desired holding. In *Russell, supra*, this Court, in reversing an earlier Ninth Circuit decision on ERISA fiduciary liability, expressly disapproved the " 'blue pencil' method" of interpretation—"omitting all words not part of the clauses deemed pertinent to the task at hand." 473 U.S. at 142. This cardinal requirement that the ERISA statute must be read logically and as a whole remains valid in 1997.

Consequently, this Court should grant certiorari both to correct a significant statutory construction error in the Ninth Circuit's decision, one affecting every plan, and to settle a circuit conflict as to whether persons who handle plan assets or have check-writing authority under plan rules automatically becomes ERISA "fiduciaries."

III. THE DECISION BELOW, WHICH HAS AN IMPACT FAR BEYOND THE NINTH CIRCUIT, WARRANTS REVIEW BECAUSE IT OVERTURNS THE ACCEPTED DEFINITION OF "FIDUCIARY" FOR EVERY PLAN, THUS MAKING IT DIFFICULT FOR MILLIONS OF PLANS TO SECURE EXPERT CLAIMS-PROCESSING, AND SPURRING LITIGATION, ALL CONTRARY TO THE PUBLIC INTEREST.

The Ninth Circuit's decision warrants review not only because it is incorrect on two major points of statutory construction and conflicts with decisions in seven other circuits, but also because it will create enormous difficulty in the administration of ERISA welfare and pension plans and will spur needless litigation over issues of "fiduciary" status that Congress and the Department of Labor acted to resolve in the 1970's.

Just in terms of health care plans alone, in the United States there are an estimated 4.5 million employer-

sponsored plans.[8] These health care plans cover over 159 million individuals[9] and, for 91% of these plans, some portion of claims-handling and payment is performed for reasons of economy and expertise by parties other than the employers, such as contract service-providers, Blue Cross/Blue Shield plans and commercial insurers.[10] Virtually all of these plans and administrative services agreements utilize the Department of Labor's broad "safe-harbor" from fiduciary status. Many of these plans, moreover, are multistate in operation.

Congress had a plain vanilla choice when it enacted ERISA. It could have made both *initial* claims-handling and payment under plan rules, and the review procedure for *denied* claims, fiduciary responsibilities subject to personal liability and federal court litigation, or it could have made the former non-fiduciary and the latter fiduciary. Alternatively, it could have left the nation without a workable standard for determining "fiduciary" status in the claims context. Congress sensibly chose the middle option as demonstrated with striking clarity by § 503 of ERISA, the broad "safe-harbor" in the Department of Labor's 1975 questions and answers, the 1977 claims regulations, and the consistent, well-developed body of law in seven other circuits. Congress and the Department of Labor wisely decided to keep the initial claims-processing and payment phase of all ERISA plans simple, non-adversarial and nonfiduciary, but subject to ERISA's bonding requirements. Among other points, Congress and the administrative agency did not want every person unhappy with an initial error to be able to sue a contract service-provider for breach of contract or breach of fiduciary duty. These suits would only be one more item to "extend

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[8] ADMINISTRATION OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT, REPORT OF THE SECRETARY OF LABOR TO CONGRESS at *i* (1987).

[9] STATISTICAL ABSTRACT OF THE UNITED STATES, p. 120 (116 ed. 1996).

[10] FOSTER HIGGINS SURVEY, 18-19.

the delays and costs of all ERISA procedures." *Snow v. Standard Ins. Co.*, 87 F.3d 327, 333 (9th Cir. 1996).

Review is necessary because the Ninth Circuit's decision will have significant adverse impacts on (literally) millions of employee benefit plans across the country, welfare plans and pension plans alike. First, the decision touches all plans and will make it extremely difficult and expensive, if not impossible, for many plans to obtain cost-effective and experienced third-party administrators, including Blue Cross/Blue Shield organizations and commercial insurers. Under the decision, a party merely engaged in initial claims-processing and payment under the plan's rules exits the "safe-harbor" and becomes a "fiduciary" if it simply does what a machine cannot do: make an eligibility decision. It may avoid ERISA fiduciary liability only by "declining to exercise *any* discretion in administering the plan—*a severe restriction of the service provider's function that may be unacceptable to plan sponsors.*" [11] Without these professional services, small and mid-range employers may not be able to provide self-funded employee benefit plans at all. Alternatively, if employers take the work "in house," there will be a corresponding loss of privacy in employee medical records, as well as a loss in claims-handling efficiency and expertise.

Second, the decision will encourage plaintiffs across the nation to use the Department of Labor's questions and answers—notwithstanding their clear text to the contrary —to convert every contract service-provider, Taft-Hartley trust employee, and bonded "plan official" into an ERISA fiduciary, attempting to saddle them with *personal* liability (§ 409(a), 29 U.S.C. § 1109(a)). This transaction-by-transaction litigation over the "fiduciary" status of parties who are in the broad "safe-harbor" will only serve to spike plan costs upwards which, in turn, will ultimately require employers to reduce benefits or possibly even elimi-

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[11] F.A. BRODIE & J.D. GATTER, "When Are Claims Administrators ERISA Fiduciaries," PENSION & BENEFITS WEEK 7 (June 9, 1997) (emphasis added).

nate certain benefits, *see Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 13 (1987). All of this is both senseless and contrary to the "strong public interest in encouraging the formation of employee benefit plans," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). The impact will be especially detrimental on health care plans that are already ensnared in ever-increasing cost spirals.

In summary, unless reversed the Ninth Circuit's decision will have adverse legal and financial impacts far outside the circuit, seriously eroding two of Congress's most important goals—encouraging the formation of ERISA plans and national uniformity of regulation. In destroying the contract service-provider's intentionally broad "safe-harbor," the decision will upend the common-sense distinction between nonfiduciary and fiduciary claims-processing and payment activities that is embodied in the statutory and regulatory scheme and honored by seven other circuits. It will encourage needless forum shopping and pointless litigation. In addition, it will hamper cost-effective, seasoned plan administration and medical records confidentiality, at the same time trampling the interest in judicial economy. Review by this Court therefore is essential not only to correct the decision's disconcerting errors in statutory construction, but to resolve a significant circuit conflict—one affecting every plan—over ERISA's definition of "fiduciary" in § 3(21)(A).

CONCLUSION

For the foregoing reasons, petitioner urges the Court to grant certiorari in this case.

Respectfully submitted,

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September 22, 1997

APPENDIX

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APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 94-55947
D.C. No. CV-94-00524-SVW

IT CORPORATION; IT CORPORATION BENEFIT PLAN;
HARRY JOSEPH LUKOWSKI,
Plaintiffs-Appellants,

v.

GENERAL AMERICAN LIFE INSURANCE COMPANY,
Defendant-Appellee.

Appeal from the United States District Court
for the Central District of California
Stephen V. Wilson, District Judge, Presiding

Argued and Submitted December 12, 1995
Pasadena, California

Filed March 3, 1997

Before: Procter Hug, Jr., Chief Judge, Robert R. Beezer, and Andrew J. Kleinfeld, Circuit Judges.

Opinion by Judge Kleinfeld

OPINION

KLEINFELD, Circuit Judge:

The issue in this ERISA case is whether a health benefits plan administrator can be sued as a fiduciary. We conclude that in this case dismissal of the claims against the administrator was error, because of questions regarding the administrator's discretionary authority, and also its control of plan money.

Facts

The district court dismissed this action on the ground that the defendant was, under its contractual undertaking, not an ERISA fiduciary. Though the case came before the district court on a 12(b)(6) motion to dismiss, the court considered the contracts between IT Corporation and General American (attached to the motion), as well as the complaint, so we review the dismissal de novo as on summary judgment. United States v. Grayson, 879 F.2d 620, 625 n.8 (9th Cir. 1989). The appeal does not argue procedural irregularity, so we do not consider it.

IT Corporation hired General American Life Insurance Company to administer IT's ERISA plan. Under the Administrative Services Agreement which General American had IT Corporation sign, IT was to establish a bank account and keep enough money in it to cover checks. General American had checkwriting authority. General American was to process claims, and pay or deny them. The contract says that Geenral American "shall pay all claims which it has determined to be payable under the agreement, except . . . all contested or doubtful claims or benefits amounts shall be referred to the client for its determination of liability and instruction."

The complaint alleges that General American paid over $600,000 for medical expenses relating to an IT Corporation employee's dependent child. According to the complaint, the child was ineligible for benefits, and General American paid $600,000 from the ERISA plan bank ac-

count in violation of the terms of the plan. There are three plaintiffs: the plan, IT Corporation, and a participant-employee.

The plan included a number of clauses designed to limit General American's liability in the event of error or misjudgment. IT Corporation and General American agreed that General American would be "acting only as agent of" IT, and would "not be liable for any mistake of judgment or other action taken in good faith, or for any loss unless resulting from its gross negligence." One clause in the agreement General American obtained from IT said that "under no circumstances shall the service contractor [General American] be considered the named fiduciary under the Plan." The agreement further provided: "Each individual administrative act, decision and interpretation by [General American] (including any errors, clerical or otherwise) shall be binding upon the [IT] with respect to past performance or completed action."

Basically, General American was supposed to refer doubtful claims to IT, but IT would ordinarily not even know about a claim unless and until General American exercised its judgment to decide that the claim was doubtful. In routine medical claims, General American was to conduct "verification of employee eligibility as to coverage and benefits" and provide "claim control practices," and then pay the claims as it deemed appropriate and provide monthly reports of claim payments. General American was to "consult with [IT Corporation] or legal counsel designated by [IT] in claim matters that are beyond the ordinary." The contract provided that General American "shall investigate the validity of each claim . . . and shall compute the benefits payable, if any, on each such claim." Then General American "shall pay all claims which it has determined to be payable under the agreement," except that "[a]ll contested or doubtful claims or benefit amounts shall be referred to the client

for its determination of liability and instruction to the service contractor." IT Corporation retained authority to "resolve any disputes which may arise with regard to the rights of persons covered under the Plan, including but not limited to eligibility for participation and claims for benefits."

Analysis

1. Contractual Exoneration.

Though General American did much to exonerate itself from responsibility by means of the contract it had IT Corporation sign, the contractual exoneration cannot do it much good in this case. There are several reasons why not. First, a contract exonerating an ERISA fiduciary from fiduciary responsibilities is void as a matter of law. Second, a fiduciary's contract with an employer cannot get it off the hook with the employees who participate in the ERISA plan. They did not sign a contract exonerating the fiduciary. Third, a contract providing that a party is not a named fiduciary does not mean that it is not an unnamed fiduciary. Fourth, discussed in section 2, below, the contract does not limit General American's tasks to the purely ministerial.

If an ERISA fiduciary writes words in an instrument exonerating itself of fiduciary responsibility, the words, even if agreed upon, are generally without effect. With exceptions not relevant to this case, ERISA provides that "any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under this part shall be void as against public policy." 29 U.S.C. § 1110(a). If General American is a fiduciary, as defined in section 1002(21)(A), "any interpretation of the Plan which prevents [General American] acting in a fiduciary capacity from being found liable as [a] fiduciar[y] is void." *Kayes v. Pacific Lumber Co.*, 51 F.3d 1449, 1460 (9th Cir.), cert. denied, 116 S.Ct. 301 (1995). "ERISA defines fiduciary not in terms of formal trusteeship, but in func-

tional terms of control and authority over the plan, thus expanding the universe of persons subject to fiduciary duties—and to damages—under § 409(a)." *Id.* at 1459 (quoting *Mertens v. Hewitt Assocs.*, 113 S. Ct. 2063, 2071 (1993)) (emphasis in original).

Even if General American could by contract exonerate itself from fiduciary responsibilities to IT Corporation, there is no reason to suppose that the contract would exonerate General American from its duties to participants and beneficiaries of the ERISA plan. 29 U.S.C. §§ 1104, 1110(a); cf. Restatement (Second) of Trusts § 216, comment i (1959). The participant-employee plaintiff did not sign the contract with the exonerating provisions, and he is entitled to have the plan administered in the interest of participants and beneficiaries. 29 U.S.C. § 1104. The ERISA Plan itself also sued for breach of what it claimed was General American's fiduciary responsibility to the Plan.

The contract says that "under no circumstances shall the service contractor [General American] be considered the named fiduciary under the Plan." The word "named" in this provision leaves open the possibility that General American may be an unnamed fiduciary. There is a difference under ERISA, between a "named fiduciary," under 29 U.S.C. § 1102(a), and a "fiduciary" under 29 U.S.C. § 1002(21)(A). Named fiduciaries are a subset of fiduciaries.

2. Fiduciary Status.

The most substantial argument for exonerating General American is that it was not a fiduciary, because its duties were purely ministerial. The contract says:

> It is understood that the Service Contract [General American] performs purely ministerial functions for the Client [IT Corporation] within a framework of

> policies, interpretations, rules, practices and procedures made by the Client.

Though based on the contract, General American's "purely ministerial" argument is not subject to the weaknesses of contractual exoneration. It is one thing to say "we promise to act as a fiduciary, but we shall not be subject to the liabilities of fiduciaries to beneficiaries." That generally cannot be done. It is different to say "we will do certain things for you, but only cut and dried things under your direction, not any of those acts which would make us a fiduciary." That can work. If a fiduciary tells a bookkeeping service to send a check for $950 to Mercy Hospital, the bookkeeping service does not thereby become a fiduciary.

The words General American used in its contract, "purely ministerial functions," were obviously written to fit the established legal understanding of what acts could be done without turning General American into a fiduciary. The Department of Labor has issued "questions and answers" regarding the distinction between persons performing "ministerial duties" and fiduciaries. These "questions and answers" distinguish persons performing "purely ministerial functions" from fiduciaries:

> Only persons who perform one or more of the functions described in section 3(21)(A) of the Act with respect to an employee benefit plan are fiduciaries. Therefore, a person who performs purely ministerial functions such as the types described above, for an employee benefit plan within a framework of policies, interpretations rules, practices, and procedures made by other persons is not a fiduciary because such person does not have discretionary authority or discretionary control respecting management of the plan, does not exercise any authority or control respecting management or disposition of the assets of the plan, and does not render investment advice with respect

> to any money or other property of the plan and has no authority or responsibility to do so.

29 C.F.R. § 2509.75-8 at D-2 (emphasis added). But putting the magic words in the contract, "purely ministerial duties," does not avoid fiduciary responsibility, if the characterization, "purely ministerial duties," is not correct. The issue is not just how the duties are characterized, but what they are.

The plaintiffs' theory is that General American breached its fiduciary duty to Plan participants by paying over $600,000 on a non-eligible claim, thereby depleting the amount available for proper claims. If General American was a fiduciary, and if it breached its fiduciary duty, then it would have to make good any loss resulting from its breach. 29 U.S.C. § 1109(a). General American argues it was not a "fiduciary" as defined by ERISA. We conclude, for two reasons, that General American may be a fiduciary, and was not entitled to judgment as a matter of law on this record that it was not. First, its discretionary authority and control may exceed what could properly be characterized as "purely ministerial" activities. Second, authority and control over plan assets may make it a fiduciary.

a. Discretionary Authority.

ERISA makes a person who exercises "discretionary authority or discretionary responsibility" in plan administration a fiduciary:

> . . . [A] person is a fiduciary with respect to a plan to the extent [i] he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, . . . or [iii] he has any discretionary authority or dis-

> cretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A) (emphasis added).

The Department of Labor's "questions and answers" do not resolve whether General American's duties respecting IT Corporation's ERISA plan were "discretionary" or "purely ministerial." "[P]ersons who have no power to make any decisions as to plan policy, interpretation, practices or procedures" are not fiduciaries. 29 C.F.R. § 2509.75-8 at D-2. A plan employee "whose sole function is to calculate the amount of benefits to which each plan participant is entitled in accordance with a mathematical formula," does not thereby become a fiduciary. But a plan employee "who has the final authority to authorize or disallow benefit payments in cases where a dispute exists" is a fiduciary. *Id.* at D-3.

One could say that General American has no final authority to authorize or disallow benefits in disputed cases, because the contract requires it to refer disputed cases back to IT Corporation. But it is hard to say that General American has no power to make decisions about plan interpretation, because General American has to interpret the plan to determine whether a benefits claim ought to be referred back. No claim is likely to be known to or disputed by IT Corporation unless and until General American decides that it is questionable or doubtful enough to be worth referring back to IT Corporation for instructions.

ERISA health benefits in this case cannot be calculated from a mathematical formula, as retirement benefits might be if the plan made them depend solely on date of birth, date of entry into service, gross pay for last three years of service, and date of retirement. So far as the record shows, this ERISA plan did not have a schedule of illnesses and medical treatments with a dollar limit, to delineate routine claims from those which should be referred back to IT

Corporation. So far as we can tell from the record, General American's decisions about claims would have to have involved plan interpretation and judgment, not just typing a treatment code number and treatment provider identification onto a computer screen for generation of a payment check. The contract says that General American "performs purely ministerial functions for the client within a framework of policies, interpretations, rules, practices and procedures made by the client." That framework is strikingly elaborate for its application to be purely ministerial. Federal appellate judges merely apply law to facts within a framework of statutes, rules, and precedent which binds them, but because of the multifariousness of facts and complexities of application of this elaborate framework, the task often involves difficult and close questions of judgment. Calling interpretation and judgment "purely ministerial" does not make it so.

There is tension between our decisions in *Yeseta v. Baima,* 837 F.2d 380, 385-86 (9th Cir. 1988) and *Kyle v. Pacific Administration Services, Inc.,* 990 F.2d 513 (9th Cir. 1993), regarding whether a firm providing services is an ERISA fiduciary. In *Yeseta,* the person managing the profit sharing plan was instructed by one of the principles in the company to pay him an amount in excess of what he was entitled to. We held that whether the person "was authorized to make the . . . withdrawals or not, he did exercise control over and disposed of Plan assets. His acts in this respect were not ministerial. On this basis, Yeseta is a fiduciary under § 1002(21)." *Id.* at 386. On the other hand, in *Kyle,* we held that a health plan administrator which was to "refer all discretionary questions regarding the payment of claims" to the employer was not a fiduciary, because its functions were "merely ministerial." See 990 F.2d at 516.

Kyle is distinguishable because the question there was merely whether paying non-covered claims, paying claims twice, and paying them late, was enough power to make

the administrator a fiduciary. The power to err, as when a clerical employee types an erroneous code onto a computer screen, is not the kind of discretionary authority which turns an administrator into a fiduciary. It may turn out, when the record is more fully developed, that General American had no discretion, and was just hring clerical employees to type codes and mail checks, but the record does not now show that its duties were purely ministerial. For all we know from the record as it stands, General American paid $600,000 on a non-covered medical claim, not through clerical error, but because it had considerable discretion and made a misjudgment about plan interpretation. That would be more like *Yeseta*.

b. Control Over Assets.

There is a second reason, which does not depend on whether General American had discretion, why it may be a fiduciary. The record as it stands shows that General American controlled the money in the plan's bank account. The statute treats control over the cash differently from control over administration. The statutory qualification, that control must be "discretionary" for it to establish fiduciary status, applies to the first and third phrases, management and administration but not to the second, assets. "Any" control over disposition of plan money makes the person who has the control a fiduciary:

> . . . [A] person is a fiduciary with respect to a plan to the extent [i] he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, . . . or [iii] he has any discretionary authority or discretionary responsibility in the administration of such plan.

On the record as it stands, IT Corporation was to keep the plan bank account filled with money, and General

American would write checks on the bank account. IT was to set up a bank account, "as the depository for funds to be used by [General American] to make payments." IT was required to notify the bank that General American was authorized "to issue and accept checks drawn on such account." IT had the "responsibility to maintain funds in this account sufficient to cover all checks validly issued by the service contractor's authorized employees." This provision means that a practical matter, a substantial amount of money would be under the control of General American, in the form of a bank account which it could deplete by writing checks.

The right to write checks on plan funds is "authority or control respecting management or disposition of its assets." We need not decide, because the case never got to the stage of cross motions for summary judgment, whether General American's authority to instruct the plan's bank to pay money to the order of drawees makes it a fiduciary as a matter of law. Its authority under the plan to do so cannot be reconciled with holding that it is a non-fiduciary as a matter of law. Only that issue is before us because of the early stage at which the case was dismissed. The words of the ERISA statute, and its purpose of assuring that people who have practical control over an ERISA plan's money have fiduciary responsibility to the plan's beneficiaries, require that a person with authority to direct payment of a plan's money be deemed a fiduciary.

Authority over a plan's money is not the same thing as being a depository of the money. If the plan's money is deposited in a bank, that does not ipso facto make the bank a fiduciary. *Arizona State Carpenters Pension Trust Fund v. Citibank* (*Arizona*), 96 F.3d 1310, 1317 (9th Cir. 1996). When money is deposited in a bank, generally the bank has no authority over who the money is paid to, and the bank manages its own money, not the depositor's,

because the depositer loans its money to the bank for its own use. People with checking accounts do not worry that their banks will pay out their money to persons of the bank's choice, because the bank has no authority or control entitling it to pay anyone but payees and endorsees on checks. Unlike Citibank in *Arizona Carpenters,* General American had authority to write checks, that is, to dispose of plan assets.

CONCLUSION

The judgment dismissing the claims is REVERSED. The case is REMANDED for further proceedings.

[Filed May 24, 1994]

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CV 94-0524 SVW (Sx)

IT CORPORATION, *et al.*,
Plaintiffs,

v.

GENERAL AMERICAN LIFE INSURANCE COMPANY,
Defendant.

ORDER GRANTING MOTION TO DISMISS

In this matter, Plaintiffs allege that Defendant General American Life Insurance Company ("General American") breached its statutory ERISA fiduciary duty under 29 U.S.C. § 1104. General American moves to dismiss on the ground that the underlying Administrative Services Agreement between General American and Plaintiff IT Corporation establishes that General American is not an ERISA fiduciary under 29 U.S.C. § 1002(21). The Court agrees and the motion will be granted.

This issue is governed by *Kyle Railways v. Pacific Administration Services, Inc.*, 990 F.2d 513 (9th Cir. 1993). In *Kyle*, the Ninth Circuit held that an entity is an ERISA fiduciary only if the entity exercises *discretionary* authority or control respecting the management or administration of an employee benefit plan. *Id.* at 516. In *Kyle*, as in the present case, the plan sponsor sought to sue the plan's administrator for "paying claims not covered under the plan." *Id.* at 515. Without quoting the contractual provi-

sions involved in the dispute, the Ninth Circuit held that the plan administrator was not given any discretionary authority under the administration agreement and that the administrator was therefore not a fiduciary under ERISA. *Id.* at 516.

In order to determine whether *Kyle* directly governed the present matter, the Court has obtained from the Ninth Circuit the briefing underlying the *Kyle* decision. As established in the appellant's opening brief in *Kyle*, the Kyle plaintiff unsuccessfully urged a finding of fiduciary duty for the plan administrator, Pacific, based on the following contractual provisions:

> (1) If requested Pacific would prepare an employee booklet describing eligibility, benefits, limitation and exclusions, and any changes thereto;
>
> (2) Pacific will determine the eligibility of employees to receive payment and shall determine in accordance with the Plan the qualification of claims submitted by such eligible employees making such reasonable investigation as shall be deemed necessary by Pacific;
>
> (3) Pacific will submit a monthly accounting to Kyle of the amounts spent on behalf of Plan participants;
>
> (4) Kyle shall deposit with Pacific the sums that Pacific determines are necessary in order to pay claims and other expenses connected with the administration of the claim.

In reaching the conclusion that these obligations did not create a fiduciary duty, the *Kyle* Court relied in large part on 29 C.F.R. § 2509.75-8(D-2). Subsection D-2 lists the following as ministerial functions not creating a fiduciary relationship:

> (1) *Application of rules determining eligibility for participation and benefits;*

(2) Calculations of services and compensations credits for benefits;

(3) Preparation of employee communications material;

(4) Maintenance of participants' service and employment records;

(5) Preparation of reports required by government agencies;

(6) *Calculation of benefits;*

(7) Orientation of new participants and advising participants of their rights and options under the plan;

(8) Collection of contributions and applications of contributions as provided in the plan;

(9) Preparation of reports concerning participation benefits;

(10) *Processing of claims;*

(11) Making recommendations to others for decisions with respect to plan administration. (emphasis added).

The present plaintiffs rely upon the following obligations of General American under their "Administrative Services Agreement" in support of the claim that a fiduciary duty existed:

(1) Evaluate evidence of good health for late enrollees;

(2) Claim control standards and practices;

(3) Verification of employee eligibility as to coverage and benefits—IT Corporation is required to supply information concerning changes in employee coverage; and

(4) Audit procedures and claim practices.

These responsibilities are precisely the type of plan administration responsibilities that are addressed by *Kyle* and by Subsection (D)(2).

The Court further notes that *Kyle* specifically addressed other contractual provisions that are also present in the contract underlying the present dispute. As in *Kyle*, the Administrative Services Agreement requires the administrator to refer all discretionary questions regarding the payment of claims to the employer. ("[General American] shall consult with [IT Corporation] in claim matters that are beyond the ordinary.") ("All contested or doubtful claims of benefit amounts shall be referred to [IT Corporation] for its determination of liability.") Also, as in *Kyle*, the Administration Services Agreement requires General American to follow the Plan *as established by* IT Corporation.

While Courts outside this circuit may disagree, *see Greenblatt v. Prescription Plan Services Corp.*, 783 F. Supp. 814 (S.D.N.Y. 1992), Ninth Circuit law establishes that plan administrators that determine eligibility for plan benefits, under the circumstances herein, are not ERISA fiduciaries. Therefore, the motion to dismiss must be granted.

THE COURT HEREBY ORDERS THAT THE MOTION TO DISMISS IS GRANTED.

IT IS SO ORDERED.

DATED: May 17, 1994

/s/ Stephen V. Wilson
STEPHEN V. WILSON
United States District
Judge

[Filed Jun. 23, 1997]

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 94-55947
D.C. No. CV-94-00524-SVW

IT CORPORATION, IT CORPORATION BENEFIT PLAN;
HARRY JOSEPH LUKOWSKI,
Plaintiffs-Appellants,

v.

GENERAL AMERICAN LIFE INSURANCE COMPANY,
Defendant-Appellee.

ORDER

Before: HUG, Chief Judge, BEEZER, and KLEINFELD, Circuit Judges.

The panel has voted to deny the petition for rehearing. Chief Judge Hug and Judge Kleinfeld have voted to reject the suggestion for rehearing en banc. Judge Beezer so recommends.

The full court has been advised of the suggestion for rehearing en banc, and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35(b).

The petition for rehearing is DENIED and the suggestion for rehearing en banc is REJECTED.

[Filed Jan. 25, 1994]

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

Case No. 94 0524 SVW

IT CORPORATION; IT CORPORATION BENEFIT PLAN; HARRY JOSEPH LUKOWSKI,
Plaintiffs,

vs.

GENERAL AMERICAN LIFE INSURANCE COMPANY,
Defendant.

COMPLAINT FOR BREACH OF FIDUCIARY DUTY BY ERISA FIDUCIARIES

Plaintiffs allege:

GENERAL ALLEGATIONS

1. Jurisdiction of this Court is invoked pursuant to 29 U.S.C. Section 1132(e) on the basis that this action is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. 1001, et. seq.

2. Plaintiff IT Corporation is the plan sponsor of the IT Corporation Benefit Plan. Plaintiff IT Corporation Benefit Plan ("IT Plan") is a self-funded plan which provides hospital and medical benefits to its members. Defendant General American Life Insurance Company ("General American") is the administrator for the IT Plan. Plaintiff Harry Joseph Lukowski is an employee of IT Corporation and a participant in the IT Plan.

FIRST CLAIM FOR RELIEF

(Claim for Breach of Fiduciary Duties by ERISA Fiduciary Against General American)

3. Plaintiffs hereby repeat and reallege Paragraphs 1 and 2 and incorporates the same as though fully set forth herein.

4. Effeceive December, 1987, plaintiff IT Corporation and General American entered into an agreement ("Administration Agreement") whereby General America would act as the Administrator of the IT Plan, a self-funded employee benefit plan.

5. The Administration Agreement required that IT Corporation deposit funds in a bank account for use by General American in paying claims made by participants and beneficiaries of the IT Plan, and that General American had the right to issue and accept checks drawn on that account. The acceptance of responsibility for these funds by General American for its use created a fiduciary duty owed by General American to the IT Plan and to its participants and beneficiaries.

6. The Administration Agreement required that General American verify the eligibility of each participant or beneficiary for benefits under the terms of the IT Plan prior to paying any claim for said benefits.

7. The terms of the IT Plan excluded from eligibility for IT Plan benefits any employee's dependent who was unable to carry on the duties and activities of a person of similar age.

8. IT Corporation employee Jim Martin submitted claims for benefits on behalf of his dependent child, Noah. Noah Martin was unable to carry on the duties and activities of a person of similar age, and was therefore ineligible for benefits under the terms of the IT Plan.

9. General American failed to verify the eligibility of Noah Martin, and paid in excess of $600,000 in claims

from the assets of the IT Plan in violation of the terms of the IT Plan, and of the Administrator Agreement between IT Corporation and General American. Said sums in excess of $600,000 were taken from the bank account wherein funds were deposited by IT Corporation for use by General American in paying claims under the IT Plan for eligible participants and beneficiaries.

10. General American refused to reimburse the assets of the IT Plan for the monies expended for payment of the claims of Noah Martin, who was not a participant or beneficiary of the IT Plan.

12. General American's acts in payment of IT Plan assets to benefit a person other than a participant or beneficiary of the subject plan are in violation of 29 U.S.C. Section 1104(A) and (B), and this action is properly brought before the Court pursuant to 29 U.S.C. Section 1009(a) and 29 U.S.C. Section 1132(a).

13. As a result of General American's acts in refusing to reimburse the IT Plan for the sums paid in violation of the terms of the IT Plan, the IT Plan's assets have been depleted by all such sums, to the detriment of the IT Plan's participants and beneficiaries. Payment of such sums in violation of the terms of the IT Plan was a breach of General American's express and implied fiduciary duties towards the IT Plan's participants and beneficiaries to hold said assets solely for their benefit, and distribute said assets solely on the behalf of the participants and beneficiaries of the IT Plan.

14. Plaintiffs are therefore entitled to receive from General American all sums taken from the IT Plan's assets for wrongful payment on behalf of Noah Martin, who was neither a participant or beneficiary of the IT Plan, and attorneys' fees, interest and costs incurred in connection with this lawsuit.

WHEREFORE, plaintiff prays for judgment as follows against defendants:

1. Recovery of all sums paid for treatment of Noah Martin;

2. Attorneys' fees;

3. Costs of suit incurred herein; and

4. For such other and further relief as this Court may deem just and proper.

DATED: January 20, 1994

GIANELLI & MORRIS

By /s/ Robert S. Gianelli
ROBERT S. GIANELLI
Attorney for Plaintiffs

EMPLOYEE MEDICAL BENEFITS PLAN DOCUMENT

Article I. Establishment of the Plan

1.1 The Plan. IT CORPORATION (the Employer) hereby establishes a plan of medical and dental benefits for its Employees. This plan will be known as the IT CORPORATION Medical and Dental Benefit Plan (the Plan) and is effective as of January 1, 1991. This Plan is designed to provide Employees and their Eligible Dependents with significant financial protection against the economic strain that might result from illness or injury.

1.2 Legal Status. This Plan will constitute an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 and has been reduced to writing in order to comply with ERISA Section 402.

1.3 Plan Document. The plan document consists of two parts: Part One includes Articles I through V and any amendments thereto; Part Two includes the attached Summary Plan description of Medical and Dental Care Benefits bearing an Effective Date of January 1, 1991, together with any amendments thereto.

Article II. Definitions

2.1 Employee means any individual employed by the Employer and to the extent necessary, a retired or terminated Employee entitled to receive benefit payments under this Plan.

2.2 Participant means an Employee who has elected to participate in the Plan.

2.3 Eligible Dependent means an individual defined under the Plan as an eligible dependent.

2.4 Plan Claim Administrator means the entity designated by the Employer to pay claims for benefits.

2.5 Plan Administrator means the Employer.

Article III. Funding

3.1 Source of Funds. The funding medium for the Plan is funds contributed by the Employer from its general assets and by Participants. The amount of Participant contributions shall be as determined by the Employer from time to time.

Article IV. Payment of Claims

4.1 Submision of Claims. Claims for benefits under the Plan shall be submitted to the Plan Claim Administrator and in accordance with the procedures described in the Summary Plan Description in effect at the time claim is submitted.

4.2 Appeal of Denied Claim. An Employee or Eligible Dependent whose claim is denied in whole or in part may appeal such denial in accordance with the claim review procedures described in the Summary Plan Description.

Article V. General Provisions

5.1 Plan Administrator. The Plan shall be administered by the Employer, which shall have the authority to construe and interpret the terms of the Plan, and resolve any disputes which may arise with regard to the rights of persons covered under the Plan, including but not limited to eligibility for participation and claims for benefits. The Administrator shall be responsible for maintaining all records relating to the administration of the Plan and for complying with all reporting, filing and disclosure requirements established by the Internal Revenue Service and Department of Labor applicable to employee welfare benefit plans.

5.2 Rules and Decisions. The Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Plan Administrator

shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, the Plan Claim Administrator, or legal counsel.

5.3 Nonalienation of Benefits. Benefits payable under this Plan shall not be assigned, transferred, or pledged as collateral prior to their actual receipt by the person entitled thereto under the terms of the Plan.

5.4 Termination and Amendments. The Employer intends that this Plan will continue in effect indefinitely, but reserves the right to amend or terminate the Plan at any time.

IN WITNESS WHEREOF, the Employer has caused this Plan to be executed by its duly authorized officers on this ____ day of _____, 19__.

_____

Title: _____

_____

Title: _____

ADMINISTRATIVE SERVICES AGREEMENT
BY AND BETWEEN
IT CORPORATION
(Herein called the Client)

AND

GENERAL AMERICAN LIFE
INSURANCE COMPANY
(Herein called the Service Contractor)

Whereas, the Client desires to provide benefits for certain classes of individuals in acordance with a written plan (hereinafter called "the Plan") as described in Appendix D;

Whereas, under said Plan the Client will bear all liabilities but desires that the Service Contractor provide certain services in connection with the administration and operation of the Plan;

Now, therfeore, in consideration of the payments to the Service Contractor as provided in the Payment Schedule, Appendix B, and subject to the terms and conditions contained herein, it is hereby agreed as follows:

Section 1. Services

The Service Contractor will provide the services listed in Appendix A subject to modification as provided herein, for the administration and operation of the Plan; such services to be coordinated by a representative of the Service Contractor to assure effective and efficient operation of the Plan.

Section 2. Banking Arrangements

The Client shall establish a separate Benefit Plan Account in a bank as the depository for funds to be used by the Service Contractor to make payments pursuant to this

Agremeent and the Plan. The Client shall notify said bank that they have authorized the Service Contractor, by execution of this Agreement, to issue and accept checks drawn on such account on behalf of the Client for the purpose of payment of benefits under the Plan. It shall be the Client's responsibility to maintain funds in this Account sufficient to cover all checks validly issued by the Service Contractor's authorized employees.

Section 3. Client Reports, Records and Information

The Client hereby agrees to furnish the Service Contractor with certain necessary reports, records, and information in order to carry out its duties hereunder.

It is mutually agreed that the Service Contractor shall not be responsible for delay in the performance of its duties under this Agreement or for non-performance hereunder. If such delay or non-performance is caused or contributed to in whole or in part by the failure of the Client to promptly furnish any required information.

Section 4. Payments to the Service Contractor

For each month in which the Service Contractor performs duties pursuant to this Agreement, the Client shall make payment to the Service Contractor of amounts due within 10 days of the date of notification to the Client by the Service Contractor. The amount due shall be determined from the Payment Schedule in Appendix B.

Charges for hourly services will be determined in accordance with the Service Contractor's established time allocation procedures, and those of other organizations from whom hourly services are purchased.

Printed material, not listed in Appendix A, will be billed for specific items furnished.

The Service Contractor shall have the right to adjust their fees as of the date (a) the Plan is amended to modify

benefits, or (b) its cost of operation is increased solely by virtue of a change in charges to the Service Contractor by a governmental unit, but such adjustment shall be limited to the amount of the change. The Service Contractor also shall have the right to adjust their fees on the annual anniversary of this Agreement and annually thereafter.

Section 5. General Provisions

(a) The Service Contractor in performing its duties under this Agreement is acting only as agent of the Client, and the rights and responsibilities of the parties shall be determined in accordance with the law of agency except as otherwise herein provided.

(b) The Service Contractor shall use reasonable care and diligence in the exercise of its powers and the performance of its duties hereunder, but shall not be liable for any mistake of judgment or other action taken in good faith, or for any loss unless resulting from its gross negligence.

(c) The Service Contractor agrees to indemnify the Client and hold the Client harmless against any and all loss, damage, and expense, including court costs and attorney's fees, resulting from or arising out of the dishonest, fraudulent, criminal acts or acts of gross negligence of the Service Contractor's employees, either acting alone or in collusion with others. The Service Contractor shall maintain Blanket Bond Coverage with a limit in reasonable proportion in the volume of claims administered.

(d) Except as provided in (c) above, the Client agrees to indemnify the Service Contractor and hold the Service Contractor harmless against any and all loss, damage, and expense, including court costs and attorney's fees, resulting from or arising out of claims, demands, or lawsuits brought against the Service Contractor in administering the Plan or to recover benefits under the Plan. Including compensatory, puni-

tive, or other damages, and including but not limited to claims for premium taxes by any governmental unit or other assessments made against the Service Contractor by governmental units.

(e) The duties to be performed by the Service Contractor under this Agreement may, at its discretion, be performed directly, wholly or in part, under a contract with an organization of its choosing.

(f) The Service Contractor shall consult with the Client or legal counsel designated by the Client in claim matters that are beyond the ordinary. In the defense of any legal action on a claim for benefits, the Service Contractor will furnish the Client and his legal counsel all pertinent information regarding the disputed claim, including the basis for its denial. The defense of any legal action on a claim for benefits shall not be the obligation of the Service Contractor.

(g) The Service Contractor shall be entitled to rely upon any communication believed by the Service Contractor to be genuine and to have been signed or presented by the proper party or parties.

The Service Contractor shall not be bound by any notice, direction, requisition, or request unless and until it shall have been received in writing, or telegraph, by the Service Contractor at its St. Louis, Missouri address, or at such other address as the Service Contractor specifies for the purposes of this Agreement by notice in writing addresed to the Client. Notices or communications from the Service Contractor to the Client shall be addressed to the Client and shall be sent by mail or telegraph to the Client at the same address designated by the Client, except as otherwise provided in Section II.

(h) The Service Contractor shall have no power or authority to alter, modify, or waive any terms or con-

ditions ofthe Plan, or to waive any breach of any such terms or conditions, or to bind the Client, or to waive any of its rights, by making any statement or by receiving at any time any notice or information.

(i) The Service Contractor shall have no power or authority to act for or on behalf of the Client other than as herein expressly granted, and no other or greater power or authority shall be implied by the grant or denial of power or authority specifically mentioned herein.

(j) The Service Contractor shall hold as the property of the Client all papers, books, files, correspondence and records of all kinds which at any time shall come into its possession or under its control relating to the transactions performed by the Service Contractor for the Client under this Agreement, and shall surrender them to the Client upon termination of this Agreement or upon prior request, except the Service Contractor may periodically destroy such material as it would usually destroy in the normal course of business.

(k) The Client shall have the right at all reasonable times to inspect at the claim office of the Service Contractor all books and documents relating to the administration of the Plan under this Agreement and which relate to such inspection. Any costs of such inspection shall be borne by the Client.

(l) Failure by the Client or the Service Contractor to insist upon compliance with any provision of this Agreement at any given time or under any given set of circumstances shall not operate to waive or modify such provision or in any manner render it unenforceable, as to any other time or as to any other occurrence, whether the circumstances, are, or are not, the same and no waiver of any of the terms or conditions

of this Agremeent shall be valid or of any force or effect unless contained in a written instrument specifically expressing such waiver and signed by a person duly authorized to sign such waiver.

No alteration or modification of the terms and conditions of this Agreement shall be valid or of any force or effect unless in each instance it is contained in a written instrument expressing such alteration or modification and executed for the Client and the Service Contractor by their officers duly authorized to execute such alteration or modification.

(m) This Agreement, including any appendices or supplements thereto, shall constitute the entire contract between the parties and shall govern the rights, liabilities and obligations of the parties hereto, except as it may be modified in accordance with the provisions of Section 5(1).

(n) Any assignment of this Agreement or of any rights hereunder shall be void and of no force or effect.

(o) It is understood that the Service Contractor performs purely ministerial functions for the Client within a framework of policies, interpretations, rules, practices and procedures made by the Client.

(p) Under no circumstances shall the Service Contractor be considered the named fiduciary under the Plan.

Section 6. Controlling Law

This Agreement shall be construed and enforced according to the laws of California.

Section 7. Separability

In the event any provision of this Agreement shall be held illegal or invalid for any reason by law or a court of competent jurisdiction, said illegality or invalidity shall not affect the remaining parts of this Agreement, but it shall

be construed and enforced as if said illegal or invalid provisions had not been included herein either initially, or beyond the date it is first held to be illegal or invalid if after the effective date of this Agreement, provided the basic purposes hereof can be effectuated through the remaining valid and legal provisions.

Section 8. Gender and Number

Any reference in the masculine gender herein shall be deemed to also include the feminine gender, unless expressly provided otherwise. Wherever appropriate, any reference in this instrument in the singular shall include the plural, and any references in the plural shall include the singular.

Section 9. Counterparts

This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, and said counterparts shall constitute but one and the same instrument.

Section 10. Currency and Place of Payments

All sums payable to, or payable by, the Service Contractor pursuant to this Agreement shall be payable in the lawful currency of the United States of America at its St. Louis, Missouri office.

Section 11. Termination of Agreement

(a) If any state or other jurisdiction enacts a law which prohibits the continuance of this Agreement, or the existing law is interpreted to so prohibit the continuance of this Agreement, the Agreement shall terminate automatically as to such time or jurisdiction on the effective date of such law or interpretation.

(b) The Client reserves the right to terminate this Agreement as of any anniversary of the effective date of this

Agreement by giving written notice to the Service Contractor at least thirty-one (31) days in advance of such date.

(c) The Service Contractor reserves the right to terminate this Agreement

(i) as of January 1, 1989, or any anniversary of that date, by giving written notice to the Client at least sixty (60) days in advance of such date, and

(ii) if the Client fails to make payments pursuant to Section 4, or to deposit funds in the Benefit Plan Account to cover checks issued by the Service Contractor. Termination of this Agreement in accordance with this item (ii) will be effective immediately upon written notice from the Service Contractor to the Client. Such notice may be by telegram, teletype, or delivered in person.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to executed by their respective officers duly authorized to do so, to effective as of December 1, 1987.

Dated at _____ this ____ day of _____.

IT CORPORATION

By /s/ [Illegible]

[Illegible]

(Official Title)

GENERAL AMERICAN LIFE INSURANCE COMPANY

By /s/ [Illegible]

[Illegible]

(Official Title)

STATUTORY PROVISIONS

ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A):

Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title.

ERISA § 402(a)(1), (b)(2), 29 U.S.C. § 1102(a)(1), (b)(2):

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(b) Requisite features of plan

Every employee benefit plan shall—

* * * *

(2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan (including any procedure described in section 1105(c)(1) of this title),

ERISA § 405(c)(1), 29 U.S.C. § 1105(c)(1):

(c) Allocation of fiduciary responsibility; designated persons to carry out fiduciary responsibilities

(1) The instrument under which a plan is maintained may expressly provide for procedures (A) for allocating fiduciary responsibilities (other than trustee responsibilities) among named fiduciaries, and (b) for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the plan.

ERISA § 412(a), 29 U.S.C. § 1112(a):

Bonding

(a) Requisite bonding of plan officials

Every fiduciary of an employee benefit plan and every person who handles funds or other property of such a plan (hereafter in this section referred to as "plan official") shall be bonded as provided in this section; except that—

(1) where such plan is one under which the only assets from which benefits are paid are the general assets of a union or of an employer, the administrator, officers, and employees of such plan shall be exempt from the bonding requirements of this section, and

(2) no bond shall be required of a fiduciary (or of any director, officer, or employee of such fiduciary) if such fiduciary—

(A) is a corporation organized and doing business under the laws of the United States or of any State;

(B) is authorized under such laws to exercise trust powers or to conduct an insurance business;

(C) is subject to supervision or examination by Federal or State authority; and

(D) has at all times a combined capital and surplus in excess of such a minimum amount as may be established by regulations issued by the Secretary, which amount shall be at least $1,000,000. Paragraph (2) shall apply to a bank or other financial institution which is authorized to exercise trust powers and the deposits of which are not insured by the Federal Deposit Insurance Corporation, only if such bank or institution meets bonding or similar requirements under State law which the Secretary determines are at least equivalent to those imposed on banks by Federal law.

The amount of such bond shall be fixed at the beginning of each fiscal year of the plan. Such amount shall be not less than 10 per centum of the amount of funds handled. In no case shall such bond be less than $1,000 nor more than $500,000, except that the Secretary, after due notice and opportunity for hearing to all interested parties, and after consideration of the record, may prescribe an amount in excess of $500,000, subject to the 10 per centum limitation of the preceding sentence. For purposes of fixing the amount of such bond, the amount of funds handled shall be determined by the funds handled by the person, groups, or class to be covered by such bond and by their predecessor or predecesors, if any, during the preceding reporting year, or if the plan has no preceding reporting year, the amount of funds to be handled during the current reporting year by such person, group, or class, estimated as provided in regulations of the Secretary. Such bond shall provide protection to the plan against loss by reason of acts of fraud or dishonesty on the part of the plan official, directly or through connivance with others. Any bond shall have as surety thereon a corporate surety company which is an acceptable surety on Federal bonds under authority granted by the Secretary of the Treasury pursuant to sections 9304-9308 of Title 31. Any bond shall be in a form or of a type approved by the Secretary, including individual bonds or schedule or blanket forms of bonds which cover a group or class.

ERISA § 503, 29 U.S.C. § 1133:

Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

REGULATIONS

29 C.F.R. § 2509.75-8(D-2, -3):

D-2 Q: Are persons who have no power to make any decisions as to plan policy, interpretations, practices or procedures, but who perform the following administrative functions for an employee benefit plan, within a framework of policies, interpretations, rules, practices and procedures made by other persons, fiduciaries with respect to the plan;

(1) Application of rules determining eligibility for participation or benefits;

(2) Calculation of services and compensation credits for benefits;

(3) Preparation of employee communications material;

(4) Maintenance of participants' service and employment records;

(5) Preparation of reports required by government agencies;

(6) Calculation of benefits;

(7) Orientation of new participants and advising participants of their rights and options under the plan;

(8) Collection of contributions and application of contributions as provided in the plan;

(9) Preparation of reports concerning participants' benefits.

(10) Processing of claims; and

(11) Making recommendations to others for decisions with respect to plan administration?

A: No. Only persons who perform one or more of the functions described in section 3(21)(A) of the Act with

respect to an employee benefit plan are fiduciaries. Therefore, a person who performs purely ministerial functions such as the types described above for an employee benefit plan within a framework of policies, interpretations, rules, practices and procedures made by other persons is not a fiduciary because such person does not have discretionary authority or discretionary control respecting management of the plan, does not exercise any authority or control respecting management or idsposition of the assets of the plan, and does not render investment advice with respect to any money or other property of the plan and has no authority or responsibility to do so.

However, although such a person may not be a plan fiduciary, he may be subject to the bonding requirements contained in section 412 of the Act if he handles funds or other property of the plan within the meaning of applicable regulations.

The Internal Revenue Service notes that such persons would not be considered plan fiduciaries within the meaning of section 4975(e)(3) of the Internal Revenue Code of 1954.

D-3 Q: Does a person automatically become a fiduciary with respect to a plan by reason of holding certain positions in the administration of such plan?

A: Some offices or positions of an employee benefit plan by their very nature require persons who hold them to perform one or more of the functions described in section 3(21)(A) of the Act. For example, a plan administrator or a trustee of a plan must, be the very nature of his position, have "discretionary authority or discretionary responsibility in the administration" of the plan within the meaning of section 3(21)(A)(iii) of the Act. Persons who hold such positions will therefore be fiduciaries.

Other offices and positions should be examined to determine whether they involve the performance of any of

the functions described in section 3(21)(A) of the Act. For example, a plan might designate as a "benefit supervisor" a plan employee whose sole function is to calculate the amount of benefits to which each plan participant is entitled in accordance with a mathematical formula contained in the written instrument pursuant to which the plan is maintained. The benefit supervisor, after calculating the benefits, would then inform the plan administrator of the results of his calculations, and the plan administrator would authorize the payment of benefits to a particular plan participant. The benefit supervisor does not perform any of the functions described in section 3(21)(A) of the Act and is not, therefore, a plan fiduciary. However, the plan might designate as a "benefit supervisor" a plan employee who has the final authority to authorize or disallow benefit payments in cases where a dispute exists as to the interpretation of plan provisions relating to eligibility for benefits. Under these circumstances, the benefit supervisor would be a fiduciary within the meaning of section 3(21)(A) of the Act.

The Internal Revenue Service notes that it would reach the same answer to this question under section 4975(e)(3) of the Internal Revenue Code of 1954.

29 C.F.R. § 2560.503-1:

Claims procedure.

(a) *Scope and purpose.* (1) This section sets out certain minimum requirements for employee benefit plan procedures pertaining to claims by participants and beneficiaries (claimants) for plan benefits, consideration of such claims, and review of claim denials, hereinafter referred to in the aggregate as "claims procedures." Except as otherwise noted, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Employee Retirement Income Security Act of 1974 (the Act).

(b) *Obligation to establish a reasonable claims procedure.* Every employee benefit plan shall establish and maintain reasonable claims procedures.

(1) A claims procedure will be deemed to be reasonable only if it:

(i) Complies with the provisions of paragraphs (d) through (h) of this section, except to the extent that it is deemed to comply with some or all of such provisions under the authority of paragraph (b)(2) or paragraph (j) of this section.

(ii) Is described in the summary plan description, as required by § 2520.102-3.

(iii) Does not contain any provision, and is not administered in a way, which unduly inhibits or hampers the initiation or procesing of plan claims, and

(iv) Provides for informing participants in writing, in a timely fashion, of the time limits set forth in paragraphs (e)(3) and (g)(3) and paragraphs (h) of this section.

(2) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees):

(i) Such plan will be deemed to comply with the provisions of paragraphs (d) through (h) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference.

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which denied claims are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (g) and (h) of this section (but will not be deemed to comply with paragraphs (d) through (f)) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which denied claims are subject (but not provisions concerning the final and initial disposition of benefit claims).

(c) *Claims procedure for an insured welfare or pension plan.* (1) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for filing of a claim for benefits with and notice of decision by such company, service or organization.

(2) See paragraph (g) regarding review and final decision on denied claims by insurance companies, insurance services and similar organizations.

(d) *Filing of a claim for benefits.* For purposes of this section, a claim is a request for a plan benefit by a participant or beneficiary. A claim is filed when the requirements of a reasonable claim filing procedure of a plan have been met. If a reasonable procedure for filing claims has not been established by the plan, a claim shall be deemed filed when a written or oral communication is made by the claimant or the claimant's authorized representative which is reasonably calculated to bring the claim to the attention of:

(1) In the case of a single employer plan, either the organizational unit which has customarily handled employee benefits matters of the employer, or any officer of the employer.

(2) In the case of a plan to which more than one unaffiliated employer contributes, or which is established or maintained by an employee organization, either the joint board, association, committee or other similar group (or any member of any such group) administering the plan, or the person or organizational unit to which claims for benefits under the plan customarily have been referred.

(3) In the case of a plan the benefits of which are provided or administered by an insurance company, insurance service, or other similar organization, which is subject to regulation under the insurance laws of one or more States, the person or organizational unit which handles claims for benefits under the plan or any officer of the insurance company, insurance service, or similar organization.

(4) For purposes of paragraphs (d)(1), (2), and (3) of this section, a communication shall be deemed to have been brought to the attention of an organizational unit if it is received by any person employed in such unit.

(e) *Notification to claimant of decision.* (1) If a claim is wholly or partially denied, notice of the decision, meeting the requirements of paragraph (f) of this section, shall be furnished to the claimant within a reasonable period of time after reecipt of the claim by the plan.

(2) If notice of the denial of a claim is not furnished in accordance with paragraph (e)(1) of this section within a reasonable period of time, the claim shall be deemed denied and the claimant shall be permitted to proceed to the review stage described in paragraph (g) of this section.

(3) for purposes of paragraph (e)(1) and (2), of this section, a period of time will be deemed to be unreasonable if it exceeds 90 days after receipt of the claim by the plan, unless special circumstances requires an exten-

sion of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the final decision.

(f) *Content of notice.* A plan administrator or, if paragraph (c) of this section is applicable, the insurance company, insurance service, or other similar organization, shall provide to every claimant who is denied a claim for benefits written notice setting forth in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

(g) *Review procedure.* (1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized representative may:

(i) Request a review upon written application to the plan;

(ii) Review pertinent documents; and

(iii) Submit issues and comments in writing.

(2) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company, service or organization. In such case, that company, service, or organization shall be the "appropriate named fiduciary" for purposes of this section. In all other cases, the "appropriate named fiduciary" for purposes of this section may be the plan administrator or any other person designated by the plan, provided that such plan administrator or other person is either named in the plan instrument or is identified pursuant to a procedure set forth in the plan as the person who reviews and makes decisions on claim denials.

(3) A plan may establish a limited period within which a claimant must file any request for review of a denied claim. Such time limits must be reasonable and related to the nature of the benefit which is the subject of the claim and to other attendant circumstances. In no event may such a period expire less than 60 days after receipt by the claimant of written notification of denial of a claim.

(h) *Decision on review.* (1)(i) A decision by an appropriate named fiduciary shall be made promptly, and shall not ordinarily be made later than 60 days after the plan's receipt of a request for review, unless special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require an extension of time for processing, in which case a decision shall

be rendered as soon as possible, but not later than 120 days after receipt of a request for review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary, which holds regularly scheduled meetings at least quarterly, a decision on review shall be made by no later than the date of the meeting of the committee or board which immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a decision may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require a further extension of time for processing, a decision shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review.

(2) If such an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension.

(3) The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, as well as specific references to the pertinent plan provisions on which the decision is based.

(4) The decision on review shall be furnished to the claimant within the appropriate time described in paragraph (h)(1) of this section. If the decision on review is not furnished within such time, the claim shall be deemed denied on review.

(i) *Apprenticeship plans.* This section does not apply to employee benefit plans which provide solely apprenticeship training benefits.

(j) *Qualified Health Maintenance Organizations.* Claims procedures with respect to any benefits provided through membership in a qualified health maintenance organization, as defined in section 1310(d) of the Public Health Service Act, as amended, 42 U.S.C. 300e-9(d), shall be deemed to satisfy the requirements of this section with respect to the provision of such benefits to persons who are members of such qualified health maintenance organization, provided those procedures meet the requirements of section 1301 of the Public Health Service Act, as amended 42 U.S.C. 300e and the regulations thereunder.

29 C.F.R. § 2580.412-4, -6:

"Funds or other property" of a plan.

The affirmative requirement for bonding persons falling within the definition of administrator, officer or employee is applicable only if they handle "funds or other property" of the plan concerned. The term "funds or other property" is intended to encompass all property which is used or may be used as a source for the payment of benefits to plan participants. It does not include permanent assets used in the operation of the plan such as land and buildings, furniture and fixtures or office and delivery equipment used in the operation of the plan. It does include all items in the nature of quick assets, such as cash, checks and other negotiable instruments, government obligations and marketable securities. It also includes all other property or items convertible into cash or having a cash value and held or acquired for the ultimate purpose of distribution to plan participants or beneficiaries. In the case of a plan which has investments, this would include all the investments of the plan even though not in the nature of quick assets, such as land and buildings, mortgages, and securities in closely held corporations. However, in a given case, the question of whether a person was "handling" such "funds or other property" so as to require bonding would depend on whether his relation-

ship to this property was such that there was a risk that he, alone or in connivance with others, could cause a loss of such "funds or other property" through fraud or dishonesty.

Determining when "funds or other property" are "handled" so as to require bonding.

(a) *General scope of term.* (1) A plan administrator, officer, or employee shall be deemed to be "handling" funds or other property of a plan, so as to require bonding under section 13, whenever his duties or activities with respect to given funds or other property are such that there is a risk that such funds or other property could be lost in the event of fraud or dishonesty on the part of such person, acting either alone or in collusion with others. While ordinarily, those plan administrators, officers and employees who "handle" within the meaning of section 13 will be those persons with duties related to the receipt, safekeeping and disbursement of funds, the scope of the term "handles" and the prohibitions of paragraph (b) of section 13 shall be deemed to encompass any relationship of an administrator, officer or employee with respect to funds or other property which can give rise to a risk of loss through fraud or dishonesty. This shall include relationships such as those which involve access to funds or other property or decisionmaking powers with respect to funds or property which can give rise to such risk of loss.

(2) Section 13 contains no exemptions based on the amount or value of funds or other property "handled", nor is the determination of the existence of risk of loss based on the amount involved. However, regardless of the amount involved, a given duty or relationship to funds or other property shall not be considered "handling", and bonding is not required, where it occurs under conditions and circumstances in which the risk that a loss will occur through fraud or dishonesty is negligible. This may be the case where the risk of mishandling is precluded by the nature of the funds or other property (e.g., checks, securi-

ties or title papers which can not be negotiated by the persons performing duties with respect to them). It may also be the case where significant risk of mishandling in the performance of duties of an essentially clerical character is precluded by fiscal controls.

(b) *General criteria for determining "handling".* Subject to the application of the basic standard of risk of loss to each situation, general criteria for determining whether there is "handling" so as to require bonding are:

(1) *Physical contact.* Physical contact with cash, checks or similar property generally constitutes "handling". However, persons who from time to time perform counting, packaging, tabulating, messenger or similar duties of an essentially clerical character involving physical contact with funds or other property would not be "handling" when they perform these duties under conditions and circumstances where risk of loss is negligible because of factors such as close supervision and control or the nature of the property.

(2) *Power to exercise physical contact or control.* Whether or not physical contact actually takes place, the power to secure physical possession of cash, checks or similar property through factors such as access to a safe deposit box or similar depository, access to cash or negotiable assets, powers of custody or safekeeping, power to withdraw funds from a bank or other account generally constitutes "handling", regardless of whether the person in question has specific duties in these matters and regardless of whether the power or access is authorized.

(3) *Power to transfer to oneself or a third party or to negotiate for value.* With respect to property such as mortgages, title to land and buildings, or securities, while physical contact or the possibility of physical contact may not, of itself, give rise to risk of loss so as to constitute "handling", a person shall be regarded as "handling" such items where he, through actual or apparent authority, can cause those items to be transferred to himself or to a third party or to be negotiated for value.

MOTION FILED
NOV 19 1997

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No. 97-520

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

GENERAL AMERICAN LIFE INSURANCE COMPANY,
Petitioner,

vs.

IT CORPORATION, et al.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF AND BRIEF *AMICUS CURIAE* OF SOUTHWEST ADMINISTRATORS, INC. IN SUPPORT OF PETITIONER

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No. 97-520

In The
SUPREME COURT OF THE UNITED STATES
October Term, 1997

GENERAL AMERICAN LIFE INSURANCE COMPANY,
Petitioner,
vs.
IT CORPORATION, et al.,
Respondents.

MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF

Pursuant to Rule 37.2(b) of the Rules of the Supreme Court of the United States, Southwest Administrators, Inc. ("Southwest") hereby requests leave to file the accompanying *amicus curiae* brief. Such brief is submitted in support of the Petition for a Writ of Certiorari filed by General American Life Insurance Company ("General American").

General American has consented to the filing of such brief. Respondents IT Corporation and Harry Joseph Lukowski have not consented.

As set forth in the accompanying brief, Southwest provides claim processing services for various employee benefit plans. In so doing Southwest applies the provisions of its clients' plans to the benefit claims it receives, and writes checks to pay those claims. Neither

it nor its clients have ever considered such routine acts to be fiduciary functions under the Employee Retirement Income Security Act of 1974 ("ERISA").

However, the decision of the Court of Appeals for the Ninth Circuit in this action profoundly changes this accepted status. Under the Ninth Circuit's analysis every claims processing entity, including Southwest, will now be considered an ERISA fiduciary. Not only will this subject Southwest and its employees to substantial personal liabilities which they heretofore have not and should not have reasonably expected, but will adversely affect the employee benefit plans they serve. Southwest will either have to charge more for its services to cover the increased exposure to liability, or will have to substantially limit the services it provides. Either action will be detrimental to the plans and to their participants and beneficiaries.

For the foregoing reasons Southwest respectfully requests leave to file the accompanying *amicus curiae* brief.

DATED: November 19, 1997.

Respectfully submitted,

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BRIEF *AMICUS CURIAE* OF SOUTHWEST ADMINISTRATORS, INC. IN SUPPORT OF PETITIONER

SUMMARY OF ARGUMENT

In *Harris Trust and Savings v. Provident Life & Accident Insurance Company*, 57 F.3d 608 (7th Cir. 1995), the Court of Appeals for the Seventh Circuit stated:

> "... the line separating fiduciaries from nonfiduciaries in the ERISA context is not a bright one." *Id.* at 617.

This is indeed correct. Determining just who is and who is not an ERISA fiduciary has been the subject of much litigation. However, despite the fact that a bright-line test may be impossible to establish in all instances, benefit claims processors could rely on a fairly simple formula: claims processing is not a fiduciary function *unless* the claims processor retains the ultimate authority to adjudicate disputed claims.

Unfortunately, the decision of the Court of Appeals for the Ninth Circuit in the within action has eradicated this simple formula. Under the analysis used by the Ninth Circuit most claim processing functions will now be fiduciary functions. Whole classes of persons, who heretofore would never have considered themselves to be ERISA fiduciaries, will now be faced with the substantial liabilities imposed by that statute.

This is not mere hyperbole, for Ninth Circuit's decision reaches far beyond the parties to the current lawsuit. As petitioner General American Life Insurance Company

("General American") pointed out in its brief, some 159 million Americans are covered by private employee health benefit plans, and for 91 percent of these plans claims processing is performed by independent insurance carriers and other third party administrators. (See Brief on behalf of General American, p. 11). The Ninth Circuit's decision, if not modified, will have a major adverse effect on *all* independent claims processors, and therefore on the entire employee benefits industry.

INTEREST OF *AMICUS CURIAE*

Amicus curiae Southwest Administrators, Inc. ("Southwest") processes pension and benefit claims for twenty labor-management employee benefit trust funds covering approximately 258,500 participants. The trust funds are established pursuant to Section 302(c)(5) of the Labor-Management Relations Act (29 U.S.C. § 186(c)(5)) and are commonly known as "Taft-Hartley" funds.

Each trust fund is governed by a board of trustees composed of representatives from employers and labor unions. The boards of trustees are the "named fiduciaries" and "plan administrators" for their respective trust funds.

Southwest is not an insurance company. Rather, it is a third party administrator known in the benefits industry as a "TPA." Like General American, Southwest processes benefit claims and performs related administrative functions for the Taft-Hartley trust funds under contractual arrangements similar to those between General American and respondent IT Corporation. Under those contractual arrangements Southwest follows and implements the benefit plans and policies

established by the boards of trustees. The trustees retain the ultimate authority to adjudicate all disputed claims.

To date neither the boards of trustees nor Southwest itself has considered Southwest to be a fiduciary simply because it processes and pays benefit claims. That common understanding has been based on ERISA itself, on applicable regulations promulgated by the Department of Labor, and on existing case law. This Court's decision, however, substantially changes the prior law, and if unmodified will dramatically alter the relationships between Southwest and its client trust funds.

Southwest therefore has a profound interest in the petition for a writ of certiorari filed by General American, and respectfully asks this Court to grant such petition.

ARGUMENT

In *Kyle Railways v. Pacific Administrative Services*, 990 F.2d 513 (9th Cir. 1993) this Court stated:

> "Third party administrators like Pacific are not fiduciaries under ERISA when they merely perform ministerial duties *or* process claims." *Id.* at 516 (emphasis added).

The maxim was repeated in *PacifiCare, Inc. v. Martin*, 34 F.3d 834, 837 (9th Cir. 1994) and has been expressly cited by other circuits. *See, e.g., Reich v. Lancaster*, 55 F.3d 1034, 1047 (5th Cir. 1995); *Harris Trust v. Provident Life*, 57 F.3d at 613. In *Klosterman v. Western General Management*, 32 F.2d 1119 (7th Cir. 1994) the court stated:

> ". . . the activities and responsibilities of [the third party administrator] in

> administering claims *as a matter of law* do not amount to discretionary authority and it is not a fiduciary." (emphasis added).

Further, in *Santana v. Deluxe Corp.*, 920 F.Supp. 249 (D. Mass 1996) the court stated:

> ". . . where an employee benefit plan has contracted with a third party to provide claims processing and other administrative services to the plan, but has retained discretion to decide disputed claims, courts have universally ruled that the service provider is not a fiduciary of the plan." *Id.* at 254.

The *only* exception has been those situations where the claims processor has retained the *ultimate* authority to grant or deny claims. *Kyle Railways v. Pacific Administrative Services*, 990 F.2d at 518; *Libby-Owens-Ford v. Blue Cross & Blue Shield Mutual of Ohio*, 982 F.2d 1031 (6th Cir. 1993). This final authority is the "crucial factor" that determines fiduciary status. *Tregoning v. American Community Mutual Insurance Company*, 12 F.3d 29, 83 (6th Cir. 1993).

As was noted in *Kerns v. Benefit Trust Life Insurance Company*, 992 F.2d 214, 216 (8th Cir. 1993) the "ultimate claims determination" exception is rooted in ERISA's claims review provisions (Section 503 of ERISA, 29 U.S.C. § 1133) and in the accompanying regulations. Section 503 requires every plan to establish a procedure whereby denied benefit claims may be reviewed by the appropriate named fiduciary. The Department of Labor has stated in its regulations that if these review functions are performed by an insurance company or similar organization then such entity becomes a fiduciary (29 C.F.R. § 2560.503-1(g)(2)).

This is consistent with the Department of Labor's Information Bulletin at 29 C.F.R. § 2509.75-8 (at D-3) which holds that a person is a fiduciary if he retains the "final authority" to grant or deny claims. It follows that where a claims processor does not retain the ultimate authority under Section 503, then it is *not* a fiduciary.

In the instant appeal, however, the Ninth Circuit did not follow the traditional and well-established analysis applicable to claims processors. It did not determine whether General American had the ultimate authority to adjudicate claims. Rather, it decided that General American may well be a fiduciary for either of two independent reasons. First, General American likely had discretionary control over plan administration because it had to exercise some judgment in interpreting IT Corporation's plan. Second, General American had authority and control over plan assets because it could write benefit checks. These conclusions are far too broad.

A. The Need For Judgment In Plan Administration Does Not Always Confer Fiduciary Status

In general terms a claims processor must do the following when it receives a health benefits claim from a participant or beneficiary:

1. Determine whether the person was eligible for benefits at the time the service was received.

2. If so, determine whether the service received was covered by the benefits plan.

3. If so, determine the amount of the benefits payable and the appropriate payee.

4. Issue the benefit check to the payee.

The foregoing services are performed by individuals known as claims adjusters. These services often involve some kind of judgment or interpretation beyond the mere entry of a treatment code. Even determining the proper payee involves some judgment: the adjuster must decide whether the benefit is payable to the participant or to the provider, which in turn requires the adjuster to decide whether an assignment of benefits exists in the form required by the plan and its policies.

But does this judgment make the claims adjuster a fiduciary? One would hardly think so, but the Ninth Circuit's opinion apparently makes a person a fiduciary whenever that person must exercise any judgment or interpretation of a benefit plan's requirements, no matter at what level that decision or interpretation is made.

As noted in the opinion, the contract between IT Corporation and General American required the latter to perform "ministerial functions for the client within a framework of policies, interpretations, rules, practices and procedures made by the client." The Ninth Circuit determined that this framework is "strikingly elaborate for its application to be purely ministerial," implying that decisions and interpretations made within that framework could indeed make General American an ERISA fiduciary. In support of this observation the Ninth Circuit noted that federal judges perform an analogous function: they "apply law to facts within a framework of statutes, rules, and precedent which binds them," but in so doing they must exercise considerable judgment.

However, carrying the judicial analogy one step further, it can also be said that the clerks at the civil filings window also act within a framework of rules and regulations imposed by the court, and they must often exercise judgment and make interpretations while acting

within that framework. Yet we know that the kinds of judgment made by an appellate judge are very different from the kinds of judgment made by a civil filings clerk. Most human beings must exercise some type of judgment or interpretation in their various vocations, no matter how routine their jobs or how detailed the instructions given to them. Indeed, the very need for such judgment is often the critical factor that determines whether a task must be performed by a human rather than by a machine.

Southwest therefore urges that fiduciary status under ERISA cannot turn simply on whether a person must exercise judgment in carrying out his or her plan administrative functions. The issue is the *type* and *degree* of judgment which is necessary or permitted in relation to the plan. In the claims processing context, the type of "judgment" that makes one a fiduciary is the final authority to grant or deny benefit claims.

The "working within a framework" concept is taken directly from the Department of Labor's regulations (29 C.F.R. § 2509.75-8 at D-2), and is the central theme in most judicial decisions concerning the nonfiduciary status of persons performing services for employee health plans. The fact that a person must exercise judgment within that framework does not make the person a fiduciary.

In *Useden v. Acker*, 947 F.2d 1563 (11th Cir. 1991) the Eighth Circuit Court of Appeals, relying in part on the Ninth Circuit's decision in *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1232 (9th Cir. 1985) held:

> "An entity which assumes discretionary authority or control over plan assets will not be considered a fiduciary if that discretion is sufficiently limited by a pre-existing framework

> of policies, practices, and procedures." *Id.* at 1575.
>
> In *accord, Reich v. Lancaster*, 55 F.3d at 1047.

It is undisputed that General American's contract limits its discretion to a pre-existing framework established by IT Corporation. The Ninth Circuit's analysis is thus directly contrary to *Useden*, *Reich*, and *Gelardi*, and indeed changes the generally accepted relationship between fiduciaries who establish the plan's administrative framework and nonfiduciaries who merely carry out administrative functions within that framework.

B. The Right To Write Checks In Itself Does Not Make A Person A Fiduciary

The alternate (and independent) basis on which the Ninth Circuit determined that General American could be a fiduciary is General American's authority to write checks. According to the Ninth Circuit such authority gives General American control over plan assets, and control over assets makes General American a plan fiduciary.

In so holding the Ninth Circuit distinguished control over assets from control over administration. While the latter requires the exercise of discretion to establish fiduciary status, the former does not. In the Ninth Circuit's opinion *any* control over plan assets, discretionary or otherwise, makes one a fiduciary.

As far as Southwest can determine, this is the first instance where a court has addressed the definitional dichotomy in ERISA § 3(21)(a)(i) (29 U.S.C. § 1002(21)(a)(i)). Unfortunately, there is no guidance in ERISA's

legislative history that would explain, one way or the other, why Congress chose to use the "discretionary" modifier in the first part of the fiduciary definition but not in the second part. It is thus not possible to tell whether any special significance should attach to this discrepancy.[1]

"ERISA makes discretion a sine qua non of fiduciary duty" *Pohl v. National Benefit Consultants, Inc.*, 956 F.2d 126, 129 (7th Cir. 1992). Yet a literal reading of Section 3(21)(a)(i) implies that this essential element is lacking when it comes to the management or disbursement of plan assets. If actions which are discretionary are to be distinguished from those which are "purely ministerial," then it follows that even "purely ministerial" authority or control over management or disposition of plan assets would make a person a fiduciary.

This would lead to bizarre results. A functionary who simply enters a treatment code and pushes a button that generates a benefits check has some degree of "control over plan assets." Under the literal reading noted above that person, by simply performing this humble function, would become a fiduciary under ERISA.

Such a literal reading of Section 3(21)(a)(i) not only leads to obviously unintended results but also conflicts with other provisions in ERISA. Section 412 of ERISA (29 U.S.C. § 1112) requires fidelity bonding for all "plan officials." Plan officials are defined as a class of persons who include both fiduciaries and every other person "who handles funds or other property" belonging to a plan. Section 412(a).

---

[1] It is also difficult to determine if any real difference was intended between the first part of Section 3(21)(A)(i) and Section 3(21)(A)(iii).

In 29 C.F.R. § 2580.412-6 the Department of Labor described what is meant by "handling" in Section 412. A plan official "handles" assets if ". . . there is a risk that such funds or other property could be lost in the event of fraud or dishonesty on the part of such person." In other words, a person "handles" if he or she has sufficient control or authority over the management or disposition of those assets to enable fraud to occur.

If in fact Section 3(21)(a)(i) applies to *any* degree of control over plan assets, it follows that anyone who "handles" assets within the meaning of Section 412 must automatically be a fiduciary. In other words, all plan officials are by reason of such status also fiduciaries. Yet as noted above the statutory definition of "plan official" includes both fiduciaries and nonfiduciaries. A literal reading of Section 3(21)(a)(i) thus yields a logical inconsistency.

Southwest submits that the kind of control over assets that makes a person a fiduciary is greater than the kind of control that merely makes one a plan official. If a person has the right to write checks against plan assets that person will always be a plan official (see 29 C.F.R. § 2580.412-6(b)). But that person would not necessarily be a fiduciary.

Whether check writing authority leads to fiduciary status should depend on the *degree* of control over asset disbursement. If the person has the ultimate authority to independently decide who should receive plan payments and how much the payments should be, then that person is a fiduciary. Conversely, if a person can write checks only in accordance with detailed instructions given by others, then that person is not a fiduciary.

Southwest realizes that the distribution of plan assets in accordance with a set of instructions is not very much different than the administration of a plan within a

framework of plan rules and policies. This suggests that the element of discretion — the right to make judgments or decisions outside of a framework imposed by others — is inherent in the fiduciary concept, even with respect to the management or disbursement of assets.

An argument can be made that this minimizes the dichotomy in the statutory definition. Yet such minimalization is not without precedent. As is evident in the cited quote from *Useden v. Acker*, 947 F.2d 1575, *supra*, the Eleventh Circuit Court of Appeals certainly links "discretion" with "authority or control over plan assets."

Whatever the distinction between control over assets versus control over administration, it is wrong to simply conclude that as a matter of law check writing authority always results in fiduciary status. This would mean that nearly every third party claims processor would be a fiduciary, since issuing benefit checks is a typical part of the processor's duties. As noted previously, this would result in a substantial change in existing law, and would be contrary to established precedent.

Southwest submits that check writing is *not* a fiduciary function if the check writer's authority is circumscribed by the terms of the plan itself and by the rules, regulations, and policies adopted by the plan administrator.

CONCLUSION

Southwest does not contend that a claims processor can never be a fiduciary. "Fiduciary status is not an all-or-nothing concept." *Kerns v. Benefit Life Insurance Co.*, 992 F.2d at 217. A person can be a fiduciary in one area of plan administration but not in others.

For example, if a claims processor has the right to adjudicate participant appeals from the denial of benefits, that right would make the processor a fiduciary. The same is true if the claims processor regularly rendered investment advice to the plan.

However, when the entity merely performs the claims processing functions outlined on p. 5 herein, it is *not* a fiduciary. Yet unless the Ninth Circuit's decision in the action is reversed, these functions would by themselves result in fiduciary status. This would not only be contrary to prior law, but would substantially alter the relationships between independent claims processors and the plan administrators who retain them, and would dramatically increase the costs of plan administration.

Accordingly, Southwest respectfully requests that General American's petition be granted.

DATED: November 19, 1997.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

GENERAL AMERICAN LIFE INSURANCE COMPANY
Petitioners,

v.

IT CORPORATION, *et al.*,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION TO FILE BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE AMERICAN COUNCIL ON LIFE INSURANCE AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

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MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* FOR THE AMERICAN COUNCIL OF LIFE INSURANCE AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

The American Council of Life Insurance ("ACLI") and the Health Insurance Association of America ("HIAA") hereby move, pursuant to Rule 37.2 of the Rules of this Court, for leave to file the attached brief as *amici curiae*. Counsel for the Petitioner has consented to the filing of this brief; counsel for the Respondents has refused consent.

ACLI represents 557 member companies that underwrite most of the nation's life and health insurance. HIAA represents more than 250 health insurance companies that cover more than 60 million Americans and that also write roughly half of the disability insurance in the United States.

As insurers, ACLI's and HIAA's member companies provide insurance benefits through employee benefit plans governed by ERISA. More specifically, many of the member companies act as Third Party Administrators ("TPAs") of ERISA benefit plans and are thus directly affected by the Ninth Circuit's decision and its far-reaching ramifications for the TPAs of such plans.

For this reason, the legal and practical consequences of the Ninth Circuit's decision are of grave concern to ACLI, HIAA, and their member companies. By imposing fiduciary status on parties that perform purely administrative, ministerial claims services, this decision, if left intact, effectively will eliminate uniformity in ERISA statutory interpretation, since the decision conflicts with the decisions of seven other federal circuit courts. It will also increase the costs of ERISA plan administration and, in some cases, may deprive ERISA benefit plans and their beneficiaries of efficient, expert administration. ACLI and HIAA seek to provide the Court with the unique perspective of their broad-based constituencies on this important federal question.

For these reasons, ACLI and HIAA respectfully request that the Court grant this motion for leave to file the attached brief

amici curiae in support of the petition for certiorari and that the Court accept that brief for filing.

Respectfully submitted,

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INTEREST OF *AMICI CURIAE*[1]

The American Council of Life Insurance ("ACLI") and the Health Insurance Association of America ("HIAA") represent the nation's providers of life, disability, health and other insurance. ACLI represents 557 member companies that underwrite most of the nation's life and health insurance. HIAA represents more than 250 health insurance companies that cover more than 60 million Americans and that also write roughly half of the disability insurance in the United States.

As insurers, ACLI's and HIAA's member companies provide insurance benefits through employee benefit plans governed by ERISA. More specifically, many of the member companies act as Third Party Administrators ("TPAs") of ERISA benefit plans and are thus directly affected by the Ninth Circuit's decision and its far-reaching ramifications for the TPAs of such plans.

For this reason, the legal and practical consequences of the Ninth Circuit's decision are of grave concern to ACLI, HIAA, and their member companies. By imposing fiduciary status on parties that perform purely administrative, ministerial claims services, this decision, if left intact, effectively will eliminate uniformity in ERISA statutory interpretation, because the decision conflicts with the decisions of seven federal circuit courts. It will also increase the costs of ERISA plan administration and, in some cases, deprive ERISA benefit plans and beneficiaries of efficient, expert administration. ACLI and HIAA seek to provide the Court with the unique perspective of their broad-based constituencies on this important federal question.

INTRODUCTION AND SUMMARY

Contrary to each of the seven other circuits that have considered whether entities that perform only claims-handling and payment duties are ERISA fiduciaries, the Ninth Circuit concluded here that a Third Party Administrator performing such

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[1] No counsel for any party had any role in authoring this brief, and no person other than the named *amici* and their counsel made any monetary contribution to its preparation and submission.

duties had "discretionary authority or discretionary responsibility" over plan administration, because, in the court's view, its claims decisions must have involved plan interpretation and judgment. See Petitioner's Appendix ("Pet. App.") at 9a. This decision conflicts not only with prior decisions of the Second, Third, Fourth, Sixth, Seventh, Eighth, and Eleventh circuits, but also ignores applicable regulatory guidance and, in the end, amounts to an impermissibly broad reading of the statutory definition of "fiduciary."

Moreover, in addition to raising fundamental concerns regarding the uniformity of ERISA statutory interpretation, the Ninth Circuit's decision has serious practical consequences for ERISA plan sponsors, TPAs, and ERISA plan beneficiaries. Ordinarily, plan sponsors and TPAs contractually allocate among themselves the various ERISA benefit plan duties and obligations, with TPAs agreeing to provide ministerial services while plan sponsors reserve to themselves discretionary authority under the plans. Once the plain language contained in such agreements no longer suffices to limit the breadth of the parties' rights and obligations, TPAs and other contract service providers will have lost the power to define and control their legal status and thereby limit their potential liability under federal law. As a result, TPAs may either cover the risk of greater liability by charging substantially more for their services — thus increasing plan administrative costs — or refuse some clients altogether, thereby depriving employers and, ultimately, beneficiaries, of efficient, expert plan administration.

For these reasons, this Court should grant certiorari to consider this important federal question.

REASONS FOR GRANTING THE PETITION

I. THE NINTH CIRCUIT'S DECISION CONFLICTS WITH THE DECISIONS OF SEVEN OTHER COURTS OF APPEALS HOLDING THAT PROVIDERS OF INITIAL CLAIMS-HANDLING AND PAYMENT SERVICES IN ACCORDANCE WITH PLAN RULES ARE NOT ERISA FIDUCIARIES.

The Court should grant certiorari in this case to resolve a conflict among the circuit courts of appeals regarding the definition of "fiduciary" under ERISA law. Specifically, the Ninth Circuit's decision to impose fiduciary status on a contract service provider based solely on its initial claims processing and payment responsibilities under an ERISA benefit plan conflicts with the decisions of seven other circuits, all of which hold that such routine claims handling and payment do not involve sufficient discretion to establish fiduciary status under ERISA § 3(21)(A).

The fact that at least eight federal circuits have considered this issue over the last decade highlights not only its intrinsic significance to employee benefit plan administrators, but also its importance to the insurance industry as a whole. The federal circuit conflict created by the Ninth Circuit's decision below is sure to trigger uncertainty, and consequently increased litigation, about this fundamental and recurring issue. A final decision by this Court resolving that conflict would obviate the need for much of that litigation.

Establishing fiduciary status for ERISA purposes turns on a party's exercise of discretion over plan administration or plan assets. By its plain terms, ERISA § 3(21)(A) provides that a party is a fiduciary only

> to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) [he renders investment advice] . . . or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A) (1994).

Seven circuit courts have held that, as a matter of law, this definition does *not* include entities performing initial claims-handling and payment activities under ERISA plans where these activities are circumscribed by employer-established plan rules and do not entail final discretionary authority. For example, in *Klosterman v. Western General Management, Inc.*, 32 F.3d 1119 (7th Cir. 1994), the Seventh Circuit considered whether TPA Western General, which contracted with employer Prairie Maize Company to administer its employee benefit plan, was a fiduciary under ERISA § 3(21)(A). Under the contract, Western General was responsible for routine claims determinations, which included processing and paying claims according to set rules and procedures established by the employer. *Id.* at 1124. The court concluded that these activities do not involve "discretionary authority" as that term is used in ERISA § 3(21)(A). The court emphasized that because the employer — not Western General — retained authority to decide all doubtful or contested claims, Western General was not an ERISA fiduciary. *Id.*

Six other circuits have reached the same conclusion. *See, e.g., Geller v. County Line Auto Sales, Inc.*, 86 F.3d 18, 21 (2d Cir. 1996) (employer not a fiduciary because its duties were not "discretionary" within the meaning of ERISA § 3(21)(A)); *Confer v. Custom Eng'g Co.*, 952 F.2d 34, 39 (3d Cir. 1991) (TPA that performed purely ministerial tasks such as claims processing and calculation and that was obligated to follow the written plan instrument did not have a discretionary role and thus was not a fiduciary); *HealthSouth Rehab. Hosp. v. American Nat'l Red Cross*, 101 F.3d 1005, 1007-09 (4th Cir. 1996) (insurance company with authority to determine eligibility for and pay benefits subject to the employer's right to modify such determinations not an ERISA fiduciary), *cert. denied*, 117 S. Ct. 2432 (1997); *Baxter v. C.A. Muer Corp.*, 941 F.2d 451, 452-56 (6th Cir. 1991) (per curiam) (TPA that processed and paid claims for a self-funded plan not a fiduciary where plan named employer fiduciary and employer reserved the right to construe the plan); *Kerns v. Benefit Trust Life Ins. Co.*, 992 F.2d 214, 216-17 (8th

Cir. 1993) (insurance company that did "nothing more than perform its normal contractual claims handling function," including initial claims processing and payment, not a fiduciary); *Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288, 291-92 (11th Cir. 1989), (administrator that processed claims and paid benefits pursuant to an employee benefit plan not a fiduciary); *see also Santana v. Deluxe Corp.*, 920 F. Supp. 249, 254 (D. Mass. 1996) (noting that courts have universally ruled that third parties that provide claims-processing and other administrative services to employee benefit plans are not fiduciaries of the plans).[2]

These decisions are consistent with not only the statute's plain words, but also with the interpretive guidance provided by the Department of Labor, the federal agency responsible for ERISA interpretation and enforcement, as to the meaning of the term "fiduciary." *See generally*, 29 C.F.R. § 2509.75-8. These regulations provide that parties performing "purely ministerial" functions are not ERISA fiduciaries. *Id.* at § 2509.75-8, D-2. The term "ministerial functions" includes, *inter alia*, determining participation or benefits eligibility, maintaining service and employment records, calculating benefits, and processing claims. *See* ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A); 29 C.F.R.

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[2] Moreover, courts have also held that, to satisfy ERISA § 3(21)(A)'s "discretionary authority" requirement for fiduciary status, an entity must have ultimate authority to conduct the ERISA appeals procedures for denied claims under ERISA § 503, 29 U.S.C. § 1133. These courts have made clear that only those entities with *final* authority to review denied claims are fiduciaries under ERISA. *See, e.g, Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288, 290 (11th Cir. 1989) (claims-handling TPA was not a fiduciary where it had "not been granted the authority to review benefits denials and make the ultimate decisions regarding eligibility"); *Libbey-Owens-Ford Co. v. Blue Cross & Blue Shield Mut.*, 982 F.2d 1031, 1032 (6th Cir. 1993) (Blue Cross was a fiduciary because it "retained authority to resolve all disputes regarding coverage"). In most cases, including the case at bar, TPAs and other contract services providers do not possess this authority.

§ 2509.75-8, D-2. An entity performing these functions is not a fiduciary because it does not have the requisite "discretionary authority or discretionary control" over plan management or plan assets under ERISA § 3(21)(A), does not "render investment advice" regarding plan money or property, and "has no authority or responsibility to do so." 29 C.F.R. § 2509.75-8, D-2.

Notwithstanding the law in every other circuit to have decided this issue, not to mention the DOL's clear regulatory guidance, the Ninth Circuit incorrectly refused to hold that, as a matter of law, General American ("GA") is not an ERISA fiduciary. The court below concluded that GA may qualify for fiduciary status even though under the Administrative Services Agreement ("ASA") that governs the relationship between GA and the IT Corporation ("IT"), GA had authority to perform only customary TPA duties such as routine claims-handling and payment in accordance with the plan's established eligibility rules. The ASA plainly does not give GA the authority to (1) interpret or construe the plan; (2) resolve appeals of denied claims; or (3) review and decide disputed claims, whereas IT did have such authority.[3] See

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[3] Indeed, § 5(o) of the ASA provides that GA was to perform "purely ministerial functions for the Client (IT) within a framework of policies, interpretations, rules, practices and procedures made by the Client." Pet. App. 30a. The ASA (Appendix C) further provides that "[a]ll contested or doubtful claims or benefits amounts" are to be "referred to the Client for its determination of liability and instruction to the Service Contractor." *See* Brief of ACLI and HIAA as *Amici Curiae* in Support of Appellee's Petition for Rehearing *En Banc*, at Exhibit 2, p. 19 (filed June 13, 1997).

Moreover, § 5.1 of the Plan Document expressly identifies IT as Plan Administrator with final authority to "construe and interpret the terms of the Plan, and resolve any disputes which may arise with regard to the rights of persons covered under the Plan." Pet. App. 23a. Specifically, IT's authority includes the power to determine "eligibility for participation and claims for benefits," which confirms that IT, as the employer — not GA — is ultimately responsible for reviewing and deciding claims that plan participants allege were handled incorrectly. As such, IT is the only ERISA "fiduciary" under the Plan.

Pet. App. 27a-30a. In short, the ASA nowhere provides — or in any way indicates — that GA shall act as plan fiduciary. Instead, the ASA expressly provides that "under no circumstances shall the Service Contractor [GA] be considered the named fiduciary under the Plan."[4] Pet. App. 30a.

Thus, in an overly-broad reading of ERISA §3(21)(A), the Ninth Circuit concluded that an entity with authority under the ASA to perform only ministerial tasks, such as routine claims processing and payment, may achieve fiduciary status by virtue of its authority to decide whether certain claims should be referred to the employer for review. Pet. App. 7a-8a. In the Ninth Circuit's view, even such limited decisions could confer sufficient "discretionary authority" upon TPAs to transform them into fiduciaries. The court reached this conclusion even though it conceded that GA arguably had no "final authority" to authorize or disallow benefits in disputed cases. *Id.* at 8a-9a. By reading ERISA's definition of "fiduciary" with "uncritical literalism," *see New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1996), the Ninth Circuit ignored Congress's intent to impose fiduciary obligations only on persons who exercise a certain threshold level of discretion in claims processing and payment, not those who merely perform the routine, ministerial tasks performed by GA here. While contract service providers necessarily exercise a

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[4] The Ninth Circuit ought not to have dismissed the party's written agreements so readily. To the contrary, courts routinely look to these agreements to determine whether their provisions confer sufficient discretion upon a party to give rise to ERISA fiduciary status. *See, e.g., Harris Trust and Savings Bank v. Provident Life and Accident Ins. Co.*, 57 F.3d 608, 613 (7th Cir. 1995) (relying on specific provisions in ASA to determine that a TPA exercised no discretion in administration of benefit plan, and therefore was not a fiduciary); *Kyle Railways, Inc. v. Pacific Admin. Servs., Inc.*, 990 F.2d 513, 516 (9th Cir. 1993) (holding ERISA health plan administrator was not a fiduciary based on plain language of ASA); *see also Baxter v. C.A. Muer Corp.*, 941 F.2d 451, 455-56 (6th Cir. 1991).

certain amount of judgment in determining claims eligibility, this "discretion" is significantly tempered and constrained by the plan's established framework of rules and policies.

Because the Ninth Circuit's decision, including both its reasoning and its ultimate conclusion, conflict with nearly a decade of federal law on this issue and, indeed, conflict with each and every circuit court to have considered this issue, the *amici* urge the Court to grant certiorari to resolve this conflict.

II. THE CONSEQUENCES OF THE NINTH CIRCUIT'S HOLDING, IF LEFT INTACT, WILL BE PROFOUND AND PERNICIOUS.

The Ninth Circuit's decision that GA — a TPA responsible for initial claims-handling and payment under plan rules — is an ERISA fiduciary has serious implications for ERISA plans across the nation. This decision will make it difficult for many plan sponsors and beneficiaries to continue to enjoy the benefits of experienced professional TPAs or other outside claims-handling agents. If service contract providers performing ministerial administrative duties are subject to ERISA fiduciary liability, such services, which have become essential to many employers, may become less available or cost prohibitive. Employers facing skyrocketing costs of plan administration could either forego professional TPA services — resulting in inconsistent and inefficient claims handling — or eliminate employee benefit plans altogether. Either way, both employers and plan beneficiaries ultimately would pay the price of poor plan administration.

A. Treating TPAs As ERISA Fiduciaries Will Result In Substantial Increases In Plan Administrative Costs That Will Be Passed On To Consumers.

ERISA fiduciaries are subject to liability for any losses to a plan caused by any action deemed a breach of fiduciary duty, and may also be subject to other legal and equitable remedies as well. *See, e.g.*, § 405, 29 U.S.C. § 1105 (liability for breach of co-fiduciary), § 409, 29 U.S.C. § 1109 (liability for breach of fiduciary duty) and § 502, 29 U.S.C. § 1132 (civil enforcement).

Under the Ninth Circuit's decision below, a TPA — with virtually no independent authority under the plan — could be subject to such liability. This result will plainly increase the already substantial administrative costs of such plans.

The average cost of plan administration by a TPA is approximately 4.7% of paid claims. Julie K. Swedback, *The Deemer Clause: A Legislative Savior for Self Funded Health Insurance Plans Under the Employee Retirement Income Security Act of 1974*, 18 Wm. Mitchell L. Rev. 757, 759 (1992). This number represents a relatively small fraction of employer costs incurred to provide employee benefits plans. If the Ninth Circuit's decision stands, these TPA administrative fees certainly will increase, making the cost of health care — already expensive — even higher for plan beneficiaries. These increased costs would negatively affect tens of millions of Americans who receive health benefits through self-funded employee benefits plans.[5] In many cases, the costs will become prohibitive, forcing some employers to forego completely hiring professional administrators, such as TPAs, for their plans.

B. Subjecting TPAs To Increased Liability As Plan Fiduciaries May Force Them To Refuse Services To Prospective Clients, Depriving Plans, Employers, And Beneficiaries Of Expert Administration.

Thousands of firms hire TPAs to administer their employee welfare benefit plans. Indeed, over 90% of all such plans are administered by either commercial insurers or TPAs. *See* 1996 Foster Higgins National Survey of Employer-Sponsored Health Plans 18-19, Brief of ACLI and HIAA as *Amici Curiae* in Support of Appellee's Petition for Rehearing *En Banc* at Exhibit 5 (filed June 13, 1997). In 1991, Aetna reported that 65% of its business results from TPA services, a figure that certainly has

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[5] More than 159 million individuals nationwide are covered by private sector group health care plans. *Statistical Abstract of the United States* at 120 (116th ed. 1996).

increased through the present. *See* Christine Woolsey, *More Small Firms Self-Fund Benefits*, Bus. Ins., Jan. 28, 1991, at 3, 12.

The reason so many employers hire TPAs is for the expert, cost-efficient administrative services that they provide. These services include custom-designed plans according to plan sponsors' needs and desires, maximum opportunity for cost-containment through more efficient, accurate claims processing, the ability to more easily identify errors and abuses that comes with personalized (and often geographically close) service, legislative and regulatory oversight, as well as uniform and comprehensive compliance with the hundreds of governmental regulatory and legislative changes mandated each year.[6]

Under the Ninth Circuit's reasoning, every insurer or non-insurance company that contracts to serve as a TPA of an ERISA benefit plan risks incurring the obligations — and concomitant potential liability — imposed upon ERISA fiduciaries, regardless of the parties' expectations as embodied in the agreement governing their relationship. If these firms are burdened with unavoidable fiduciary obligations for which they did not bargain, they may reject some clients, thus depriving employers and, ultimately, beneficiaries of efficient, expert plan administration.

Furthermore, without professional TPA services, some employers will be unable to afford self-funded employee benefit plans — resulting in less available or more expensive health care for America's workers — while others may attempt to manage

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[6] TPAs also typically perform any number of other valuable functions in administering a plan, including, for example:

- answering inquiries from participants about benefits provided;
- receiving claims and claims documents and verifying eligibility for benefits; and
- processing and issuing claim checks or drafts to participants, hospitals, doctors or others.

their plans in-house, which is sure to result in less efficient and, ultimately, more costly administration of health benefit plans.

CONCLUSION

For the foregoing reasons, *amici* urge the Court to grant certiorari in this case.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

GENERAL AMERICAN LIFE INSURANCE COMPANY,
Petitioner,

vs.

IT CORPORATION, et al.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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38pp

QUESTIONS PRESENTED

1. Where a benefit plan administrator has the ability to waste the assets of an employee benefit plan by making the final decision to grant benefits without any review, by directing payment of funds from the plan's bank account, and such decision is expressly binding on the plan, may a district court conclude, without more, that the administrator is excused as a matter of law from compliance with the obligations of a fiduciary under ERISA?

2. When an insurance company agrees to provide administrative services to an employee benefit plan under ERISA, may it simultaneously claim immunity from suit for breach of its obligations under state law (on the ground that ERISA preempts all state law obligations of persons who contract with ERISA plans) and that ERISA bars any action against it (because it is not a fiduciary)?

PARTIES TO THE PROCEEDING
and Rule 29.6 Statement

The Respondents in this case are IT Corporation, IT Corporation Benefit Plan, and Harry Joseph Lukowski.

IT Corporation is 100% owned by International Technology Corporation, a Delaware Corporation which is publicly traded on the New York Stock Exchange. IT Corporation itself, a California corporation, owns no subsidiary corporations or entities which have issued shares to the public, and has itself issued no shares to public.

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Rules

United States Supreme Court Rule 10. 4

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

OPINIONS BELOW

Respondent does not disagree with Petitioner's statement concerning the opinions below.

JURISDICTION

Respondent does not disagree with the statement of jurisdiction set forth in the Petition.

STATUTES AND REGULATIONS INVOLVED

Respondent disagrees with the statement of statutory and regulatory provisions at issue as set forth in the Petition to the extent that 29 C.F.R. § 2560.503-1 is stated to be pertinent. Same, by its terms, purports to dèal with claims made by participants or their beneficiaries. All admit that there was no such claim here.

STATEMENT OF THE CASE AND FACTUAL BACKGROUND

This matter was decided on a motion to dismiss by General American. General American introduced into those proceedings a limited showing on factual matters outside the complaint. IT Corporation, IT Corporation Benefit Plan, and Harry Joseph Lukowski (collectively "the Plan") did not object, and the matter was decided as

a type of summary judgment motion on the basis of the materials introduced.

The documents introduced by General American were the Plan's Complaint and First Amended Complaint in state court for breach of contract and other claims against General American, with exhibits. Same included the Administrative Services Agreement (the "Agreement") between the Plan and General American. (Appendix to Petition, pp. 25a-32a, and Appendix hereto, pp. A1-A7.) General American was, and is, defending that California state court action on the grounds that all claims are preempted by the Employee Retirement Income Security Act.

The Agreement identifies IT Corporation as "the Client" and General American as "the Service Contractor." (App. to Petition at 25a.) Appendix C to same, "Claims Processing and Payment," states that " . . . each individual administrative act, decision and interpretation by the Service Contractor (including any errors, clerical or otherwise) *shall be binding* upon the Client with respect to past performance or completed action." (Appendix hereto, p. A5 last paragraph, emphasis added.)

The Administrative Agreement also provided that the Plan was to open a bank account for General American's use in making payments as General American saw fit. (Appendix to Petition pp. 25a-26a "Section 2."). General American was given the authority to issue checks drawn on that account for the purpose of paying benefits under the plan. (*Id.*) In fact, failure of the Plan to deposit money in the "Benefit Plan Account" to cover the checks General American issued resulted in immediate termination of the Agreement. (Petitioner's Appendix at 32a, ¶ (c)(88).)

The Plan specifically disputes General American's contention of fact that benefit checks were provided to

IT Corporation for distribution to the medical care providers.

The District Court decided that such matters were in fact ministerial, replying on *Kyle Railways v. Pacific Administration Services, Inc.*, 990 F.2d 513 (9th Cir. 1993), and its limited description of the duties performed by the administrator.

In a unanimous opinion authored by Judge Kleinfeld, and joined by Judges Beezer and Hug, the Ninth Circuit reversed on the ground that the record was not sufficiently clear to warrant the conclusion that petitioner was not a fiduciary as a matter of law. 107 F.3d 1415 (9th Cir. 1997). The panel began by noting that, as petitioner apparently now concedes, the recitals in the Agreement that characterize petitioner's duties as ministerial and its status as nonfiduciary cannot control the legal determination of fiduciary status, which rests on the substance of the relationship and not merely its labels. 107 F.3d at 1418-1419. "Putting the magic words in the contract, 'purely ministerial duties,' does not avoid fiduciary responsibility, if the characterization . . . is not correct. The issue is not just how the duties are characterized, but what they are." *Id.* 1419. Under the terms of the Agreement, which was the only factual evidence before the Court, fiduciary duty could not be established as a matter of law. The Ninth Circuit remanded for development of the factual record as to what actually occurred in the provision of administrations services.[1]

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[1] The issue of indemnity was not brought before any court below, and is irrelevant at to the existence of fiduciary duty anyway. The fact of an indemnification contract does not create immunity from liability — there is no indemnification until there is a judgment of liability.

II

REASONS WHY THE WRIT SHOULD BE DENIED

A. The Decision Below Is an Unexceptional Application of Accepted Legal Principles to a Novel Fact Situation; It Neither Conflicts With the Holding of Any Other Circuit, Nor Presents an Unusually Important Question of Federal Law

This case does not meet the criteria for the issuance of a writ of certiorari as set forth in Rule 10 of the Rules of this Court, and the Petition should be denied. The holding of the Ninth Circuit was made on a very limited factual record, under a contract with peculiar language giving a claims administrator absolute binding authority. No case cited by General American contains such peculiar language in describing a claims administrator's duties as binding, and a ruling by this Court on this issue, in the absence of similar contract language, will resolve no conflict in the decisions of the Federal Courts. In *no* decision cited by General American was the decision made on the sole fact of an agreement conferring such final, binding authority on the administrator. There was just such an express delegation of final authority here.

Nor is the issue ripe for decision by this Court, due to the as-yet unique language which may never occur again in a reported, or indeed, an unreported decision. Uniformity of law in this area — ERISA — is desired, but as of this time, there is "uniformity" due to the singular contract language at issue. For purposes of the proceedings

below, the contract language, and only the contract language, led to the decisions below.

Lastly, petitioner's concern that requiring it and others with final authority to be responsible for their decisions will increase plan costs is a strange bird indeed. To allow those with final authority to both charge substantial sums to ERISA plans *and* to be immune from responsibility for their actions is a much more expensive proposition. In this regard, all the Ninth Circuit decided was that ERISA plans, like other entities making contracts, are entitled to receive what they paid for.

B. There Is No Conflict on the Basis of Discretionary Authority

General American tries mightily to manufacture a conflict between the decision of the Ninth Circuit in this case and the opinions of other Circuits. In order to do this, General American has to create a new rule of law, however. According to General American, a fiduciary duty can exist *only* where the entity in charge of plan assets refuses to dispose of them — e.g., a claim is denied. In short, General American asks that this Court amend 29 U.S.C. § 1002(21)(A) from its current language — "exercises any authority or control respecting management or disposition of its assets" — to state as follows: "exercises authority or control solely to refuse to dispose of plan assets." Thus, according to General American's arguments, the statute means the opposite of what it says, and disposal of plan assets is always a nonfiduciary activity.

The problem with General American's argument is, that while its cases discuss fiduciary status with regard to refusal to dispose of plan assets, they rest on another

ground which operates, as the Ninth Circuit realized, solely in the Plan's favor. The question on which General American's cases rested was discretion — who had the final authority with regard to the function at issue? Where that function was claims denial, who had final authority with regard to denial was the deciding factor. Where the function was payment, who had the final authority to bind the Plan to payment decisions would obviously also be the fiduciary for *that* function. It is finality that is the question.

In the cases cited by General American, the Courts relied on, as General American purports to do as well, 29 C.F.R. § 2509.75-8. That section expressly notes the difference between one who merely *recommends* claims payment as opposed to one who had the actual *authority* to make the payments. In the subsection cited by General American, D-3, in a part ignored by it, the regulation states, as another example of nonfiduciary status: "[t]he benefit supervisor, after calculating the benefits would then inform the plan administrator of the results of his calculations, and the plan administrator would authorize the payment of benefits . . ."

Here, of course, General American was not required to "recommend" payment; if it found payment appropriate, it had the authority to make it out of plan funds segregated for it to use in just that way, and its determination that the Plan terms allowed such payment was final and binding. The final authority to authorize payment, rather than to merely recommend, is the pertinent indication of fiduciary status. Thus, General American's cases claimed to "conflict" with the Ninth Circuit's opinion in this case, in fact support that opinion most strongly.

Walker v. National City Bank of Minneapolis, 18 F.3d 630 (8th Cir. 1994) supports the decision below. There

the Court found that while the bank/trustee was a fiduciary and a named fiduciary at that, it did not act as a fiduciary with regard to the function argued. Here, in conflict with that ruling, rather than in concert with same, General American contends that the function at issue is to be ignored, that where an entity acts as a fiduciary with regard to one function, it must be the only fiduciary as to all. There is no "conflict" between *Walker* and the decision below. The only "conflict" is with *Walker* and General American's position.

Custer v. Sweeney, 89 F.3d 1156 (4th Cir. 1996) also supports the decision below. In that case, the Court found that the ability to make only "non-binding recommendations" coupled with the fact "he lacked check-writing authority" (*Id.* at 1163) to be sufficient to show non-fiduciary status.[2] Here, General American expressly had binding authority — even in the case of error in interpretation — to authorize checks to be drawn on the Plan account, the exact opposite of evidence showing lack of fiduciary status. The only "conflict" is between the *Custer* opinion and General American's current arguments.

Santana v. Deluxe Corp., 920 F.Supp. 249, 256 (D. Mass. 1996) also relied on 29 C.F.R. § 2509.75-8, and the distinction between one who merely "recommends" and one who had the actual authority to dispose of plan assets: "Making recommendations respecting plan administration is not indicative of fiduciary status." A claim denial, for which an entity other than the one urged to be a fiduciary had ultimate authority, was the issue. Here, again, General American had the ultimate

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[2] *See LoPresti v. Terwillinger*, 126 F.3d 34 (9th Cir. 1997) for a very recent case holding that he who has the authority to order the check issued is the fiduciary.

authority with regard to its final, binding decision to pay, rather than deny, a claim.

In *Haidle v. Chippenham Hosp.*, 855 F.Supp 127 (E.D. Vir., 1994), another claims denial, with final authority resting in another entity, was involved. Again, the Court relied on 29 C.F.R. § 2509.75-8 in reaching its decision, and same expressly notes the difference between a recommendation and final authority. The case does contain some language to the effect that so long as an entity is following plan terms, it can never be a fiduciary. That language, however, cannot be read literally. As admitted by General American on page 4 of its petition, fiduciaries also have to follow plan terms, and such a loophole would free all, even named fiduciaries — who purport to act as they must — according to plan terms. The problem here, too, is that General American did *not* follow plan terms, but paid benefits to a person ineligible under the Plan's express provisions.

In *Confer v. Custom Engineering Co.*, 952 F.2d 34 (3rd Cir. 1991) the entity claimed to be a fiduciary was specifically instructed on the actual claim at issue not to pay it. Thus, the Court found, under 29 C.F.R. § 2509.75-8, there was no actual authority to make payment, and no fiduciary duty. The opposite is true here.

Libbey-Owens-Ford Co. v. Blue Cross and Blue Shield Mutual of Ohio, 982 F.2d 1031 (8th Cir. 1993) also supports the Ninth Circuit's opinion in this case. There, an insurer also handled claims for a self-funded ERISA plan. The agreement expressly required that the employer/plan keep a checking account to be used by Blue Cross filled with two month's estimated payments. The Court held that the question is whether there is discretion, not whether the discretion is exercised as a claims handler/insurer. The Court specifically relied on *The Sixty-Five Security Plan v. Blue Cross and Blue*

Shield of New York, 583 F.Supp. 380 (S.D.N.Y. 1984), concerning the fiduciary status of one who has control, discretionary or not, over disposition of ERISA plan assets to find a fiduciary duty on the part of the insurer/ claims administrator. Same also supports the decision below, and conflicts only with General American's arguments.

The decision in *Klosterman v. Western Gen. Management*, 32 F.3d 1119 (7th Cir. 1994) also supports, rather than conflicts, with the decision below. The Court held that making "recommendations" — rather than actual decisions — could not show fiduciary status: "The activities of Western General and Fallon in setting up Prairie Maize with Guarantee Mutual or in presenting insurance quotes and making recommendations at the time of renewal are insufficient as a matter of law to render Western General a fiduciary under the plan." (*Id.* at 1123.) Here, General American did not "recommend" payment to another who had the actual authority to decide to make payment — General American made the decision, and paid the $600,000, and its interpretation in doing so was binding, even though in error, under the express terms of the Agreement. There were no such provisions in the agreement between the parties in *Klosterman*. Again, the question is whether the entity has final binding authority with regard to the function at issue that determines fiduciary status. *Klosterman* expressly contrasted a situation where the employer had no authority to review "processed" claims — which was exactly the situation before the Court below.

In *Pohl v. Kellner*, 956 F.2d 126 (7th Cir. 1992), no assets were dissipated; a denied claim involved was denied. The Court there was not faced with, did not consider, and therefore did not decide whether authority or control over plan assets shows fiduciary status. It

decided, without elucidation of the basis, that the administrator performed ministerial functions.

In *Gibson v. The Prudential Ins. Co.*, 915 F.2d 414 (9th Cir.1990), the matter involved was a denied claim. The case made clear that with regard to a denied claim, TRW, not Prudential, was the fiduciary where denied benefits were involved. (*Id.* at 416: "Gibson subsequently appealed to the TRW Administrative Committee and was again denied benefits.") "Fiduciary status is not an all or nothing concept . . . [A] court must ask whether a person is a fiduciary with regard to the particular activity in question." [citation omitted.] A finding that TRW was not a fiduciary with respect to *denied* claims does not conflict with the Ninth Circuit's opinion below. The function here was not claims denial or review — it was payment, and the agreement gave General American the final authority on that, which General American used to dispose of over $600,000 in plan assets.

Kerns v. Benefit Trust Life Ins. Co., 992 F.2d 214 (8th Cir. 1993), held that with respect to the issue involved, failure to reinstate a policy the employer did not pay for, the insurer was not a fiduciary. There is no actual conflict, as the Court expressly refused to decide if claims administration was a fiduciary function, that issue not being before it. "Even if Benefit Trust was an ERISA fiduciary with respect to claims handling, we agree with the district court that it was not a fiduciary with respect to the functions at issue in this case — participant and beneficiary notification, premium payment, and policy lapse and reinstatement." (*Id.* at 217).

Nor is there any true conflict with the opinion in *Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288 (4th Cir. 1990). That case also involved a claim denied by an insurer acting as administrator, where another was the final authority on denied claims. Here,

the function is claims payment, for which General American's decision to pay was final. Even its interpretation as to what was a "disputed" claim was expressly final, binding on the plan, even if in error.

General American contends that *Blatt v. Marshall and Lassman*, 812 F.2d 810 (2nd Cir. 1987) conflicts with the Ninth Circuit's opinion below. Not so. The court specifically found that "[w]e conclude that Marshall and Lassman acted as fiduciaries in this case because they exercised actual control over the disposition of plan assets. The definition of fiduciary under ERISA focuses on the exercise, as well as the possession, of authority or control. Thus, a person is a fiduciary with respect to a plan to the extent (i) he exercises . . . any authority or control respecting . . . disposition of its assets." (*Id.* at 812.)

Healthsouth Rehabilitation Hosp. v. Nat. Red Cross,[3] 101 F.3d 1005 (4th Cir. 1996) also firmly supports the Ninth Circuit's opinion below. There, the Court specifically cited 29 C.F.R. § 2509.75-8 as controlling. That is the regulation which, as noted above, specifically states that those who "recommend" payments are not fiduciaries, in contrast with those — like General American — who have actual authority to authorize payments. The Court in *Geller v. County Line Auto Sales, Inc.*, 86 F.2d 18 (2nd Cir. 1996) also relied on that C.F.R. section, finding that one who had no authority to authorize payment could not be held a fiduciary because they lied to get benefits.

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[3] There is no explanation why the Red Cross plan, a governmental plan not subject to ERISA, was urged to be governed by ERISA. *See U.S. v. City of Spokane*, 918 F.2d 84 (9th Cir. 1990) and *Rose v. Long Island Railroad Pension Plan*, 828 F.2d 910 (2nd Cir. 1987), *cert denied*, 485 U.S. 936, 108 S.Ct. 1112, 99 L.Ed.2d 273 (1988).

In *Howard v. Parisian*, 807 F.2d 1560 (11th Cir. 1987), the Court offered no opinion on fiduciary status, as the claimant had expressly admitted lack of same. An opinion which offers no holding on the subject at issue cannot be found to "conflict" with anything. The same was true in *Baxter v. C.A. Muer Corp.*, 941 F.2d 451 (6th Cir. 1991), which also noted that 29 C.F.R. § 2509.75-8 provided the basic authority on this subject. 29 C.F.R. § 2509.75-8, as noted, requires a finding that General American is a fiduciary because it had actual authority to issue checks, not merely the ability to "recommend" they be issued.

In *Harris Trust & Savings Bank v. Provident Life and Accident Ins. Co.*, 37 F.3d 608 (7th Cir. 1995), the agreement stated that the insurer/administrator had "final" authority on such matters as "payment for charges." (*Id.* at 613.) The actual facts upon a fully developed record, however, showed that the agreement was not followed. The Court noted that since the actual facts showed the employer, not the administrator, had actually made the decision, no fiduciary status for that decision — that function — could be found in that case. Here, the only evidence placed before the district court, and the Ninth circuit, was the agreement. And the Ninth Circuit remanded to allow just the factual development to contradict that agreement. There is no "conflict." Both decisions hold that the entity which exercises the final authority with regard to the function at issue is the fiduciary.

Broemenn Healthcare v. Northwestern Nat'l. Life Ins. Co., 806 F.Supp 799 (C.D. Ill. 1992) also supports the decision below. "Whether Bromenn falls within this definition necessarily depends upon the possession of discretionary control or actual authority." (*Id.* at 804.)

"Contributions made to a plan by such employer or employee organization become 'funds' of the plan if and when segregated . . . Northeastern, as the excess risk insurer, controls only its own assets, not the assets constituting Plan funds . . . If the Subscription Agreement provided that Northwestern paid the actual benefits as opposed to reimbursing the Plan for benefits actually paid, this finding [that Northwestern was not a fiduciary] might be different." (*Id.* at 805.) Here, the "funds" *were* segregated — into a bank account General American had the final authority to dispose of — and did to the tune of $600,000 paid to a nonparticipant, nonbeneficiary.

American General cites *Chapman v. Klemick*, 3 F.3d 1508 (11th Cir. 1993) for the proposition that it cannot be a plan fiduciary with regard to its disposition of existing plan assets. In that case, the plaintiffs claimed that a personal injury attorney who had collected attorneys fees upon settlement of an ERISA plan beneficiary's personal injury action was a plan fiduciary. The plaintiffs, having obtained a full, but uncollectible, judgment for the beneficiary for plan assets paid to him for treatment of his injuries, wanted his attorney to give them his attorneys fees, under the theory that they were "plan assets" by virtue of a subrogation provision. The *Chapman* court relied on the Ninth Circuit's opinion in *Nieto v. Ecker*, 845 F.2d 868 (9th Cir. 1988), which in turn relied on *Yeseta v. Baima*, 837 F.2d 380 (9th Cir. 1988). It found that the ties the beneficiary's attorney had to the plan were even more tenuous than found in *Nieto*, because the attorney rendered *no* services to the plan.

General American states that *Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288 (4th Cir. 1990) conflicts with the opinion of the Ninth Circuit below.

That case involved a denied claim. The Court based its holding specifically on the fact that the administrator did not have final decision-making authority over the function involved — claims denial. Here, General American did have such final authority over the claim at issue, a paid claim. The Court did not decide the issue at hand, whether final authority to pay a claim from plan assets, when such authority was made binding on the Plan whether in error or not, shows a fiduciary duty in the function at issue.

In *Eaton v. Aetna Cas. & Surety Co.*, 581 F.Supp 743 (D.D.C. 1980), the third-party administrator "adjudicated varied and substantial medical claims for reimbursement in which its judgment as to what charges or amounts were fair, reasonable, and customary was in effect final." (*Id.* at 746-747). There, the Court expressly found that the fact a third party administrator's decision to pay a claim was final to be a strong indicator of fiduciary authority, despite the fact the administrator argued, as General American does here, that its final authority with respect to paying claims was ministerial because done within a tight framework of rules, interpretations, policies, and practices established by the plan trustees that sued it. *Eaton* was relied on by the Ninth Circuit in *Kayes v. Pacific Lumber Company*, 51 F.3d 1449, 1460 (9th Cir. 1995).

The Ninth Circuit in the opinion below expressly noted that a bank acting as a depository was not a fiduciary — thus rendering inaccurate General American's claims of a conflict with *O'Toole v. Arlington Trust Co.*, 681 F.2d 94 (1982); *Useden v. Acker*, 947 F.2d 1563 (11th Cir. 1991) (same in fact

specifically relied on the Ninth Circuit opinion in *Yeseta v. Baima*, 837 F.2d 380 (9th Cir. 1988)[4] — see page 1578).

The opinion of the Ninth Circuit below joins a long line of cases holding that it is final authority that determines whether a function in question is a fiduciary function imposing a fiduciary duty. The attempt by General American to create a "conflict" with cases holding the same, but dealing with different functions than the function here, has no support. To find that only one who refuses to dispose of plan assets had a fiduciary duty would be in direct conflict with the dictates of 29 U.S.C. § 1002(21)(A), and in direct conflict with common sense and Congressional intent to ensure protection of ERISA plan assets from wrongful waste.

C. The "Bright Line" Test Offered by General American Is a Murky Morass

General American also argues that the "tests" it puts forth are "bright line" tests which will lead to uniform, predictable results. General American admits, as it must, that it had discretion, but argues that it was not "enough" discretion, and urges that the Court overturn the Ninth Circuit's opinion below and insist that each Court determine on a case by case basis just how much "discretion" is necessary to find a fiduciary duty. In short, General American argues that not only should 29

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[4] *Yeseta v. Baima*, 837 F.2d 380 (9th Cir. 1988) has been embraced by many other Courts.. *See Greenblatt v. Prescription Plan Services Corp.*, 783 F.Supp. 814 (S.D.N.Y. 1992); *The Sixty-Five Security Plan v. Blue Cross and Blue Shield of New York*, 583 F.Supp. 380 (S.D.N.Y. 1984); *Nieto v. Ecker*, 845 F.2d 868 (9th Cir. 1988);

U.S.C. § 1002(21)(A) be read to bar fiduciary status to those who dispose of, rather than preserve, plan assets, it must also be read to bar fiduciary status to those who admittedly have discretion to the point of final authority over plan administration. Under General American's "test," each case would be decided on a subjective standard having nothing to do with either the statute, or the intent of Congress in enacting it. There could be no uniformity.

The correct, and truly "bright line," test is that which the Courts have already uniformly set forth — is the authority final and binding with regard to the function performed? If it is, then fiduciary status is found. General American's test is one in conflict with every decision General American cites, is unworkable, and would lead to flights of whimsy rather than a standard which is knowable and followable.

D. The Distinction Between "Control/ Authority" And "Handling" Is of No Aid to General American

To be sure, the Ninth Circuit did not expressly address the relevance of the bonding language, but that is undoubtedly because it was not advanced in petitioner's brief on appeal. Rather section 1112 was first cited in the petition for rehearing. Indeed, the petition does not point to a single other case from other courts of appeals that relies on the bonding argument in order to deny fiduciary status based on the improper — but final and binding — decision to pay claims. Even assuming that the argument has been preserved for review in this Court, this Court should wait to see whether the lower courts find this ground for fiduciary status troubling, and

grant review after the legal issue has been more fully developed.

In that petition for rehearing, as here, General American argued that 29 U.S.C. § 1112 in effect renders the language of 29 U.S.C. § 1102(21) (A) meaningless, and urges the over-ruling of a decade of law followed throughout all circuits confronting the function at issue — disposal of plan assets.

Judge Kleinfield's opinion below already pointed out the solution to this nonexistent quandary, noting the difference between a mere "depository" and one who has authority or control over that money. Another example would be truly ministerial acts, such as the persons within General American who put the checks into envelopes and mail them at the direction of General American.

The example offered by General American below, and the Court in *Nieto v. Ecker*, 845 F.2d 868 (9th Cir. 1988), of a janitor, would in fact have to be bonded, if he had keys to the place where the checks were kept. While such persons "handle" funds within the meaning of the statute, they do not control them and have no authority to issue the checks themselves.

This is also true of General American's new example of individual claims adjusters, in contrast to General American itself, or the very example offered by the regulation cited by General American — a "benefits supervisor" who can make recommendations only, but has no authority to make actual payment. The regulations applicable to bonding specifically state that such persons must be bonded, so long as there is a risk of loss of the funds. See 29 C.F.R. § 2580.412-6(b)(1) and (2). All who have access to the checks are to be bonded. Those who have control and/or authority over to whom the checks are made payable are fiduciaries. General

American did not merely handle checks previously authorized by The Plan — General American itself authorized the checks, and the disposal of plan funds.

Control of plan assets is in and of itself sufficient to find fiduciary duty. In *Blatt v. Marshall and Lassman*, 812 F.2d 810 (2nd Cir. 1987), the court specifically found that "appellees had no discretionary role in administering the plan" and "were found not to possess any discretionary authority with respect to management of the plan or disposition of its assets." (*Id.* at 812.) However, "[w]e conclude that Marshall and Lassman acted as fiduciaries in this case because they exercised actual control over the disposition of plan assets. The definition of fiduciary under ERISA focuses on the exercise, as well as the possession, of authority or control. Thus, "a person is a fiduciary with respect to a plan to the extent (i) he exercises . . . any authority or control respecting . . . disposition of its assets." (*Id.* at 812.) *See also LoPresti v. Terwillinger*, 126 F.3d 34 (9th Cir. 1997) for a very recent case holding that he who has the authority to sign the check is the fiduciary, and *Yeseta v. Baima*, 837 F.2d 380 (9th Cir. 1988), another widely cited case coming from the Ninth Circuit.

The Ninth Circuit's opinion, as well as being consistent with cases within and without that circuit concerning the ability to dispose of plan assets, is also consistent with Congress' intent in imposing stricter standards where plan assets were concerned: "As defined by the Act, a fiduciary is a person who exercises any control, management, or disposition with respect to monies or other property of an employee benefit plan, or who has authority or responsibility to do so." 1974 U.S. Code Cong. and Adm. News, page 4649. Further, "it is expected that the courts will interpret . . . fiduciary standards bearing in mind the special nature and purposes of

employee benefit plans intended to be effectuated by the Act." (*Id.* at 4650.)

E. The Impact of Immunity For Those Paid as Expert Administrators Defies The Concept of "Expert" And of The Premise of ERISA

As noted above, General American also contends in state court that ERISA preempts any breach of contract action against it, that there is no remedy under either federal or state law for its wrongful dispostion of $600,000 in plan assets. Thus, the administration contract is basically a gift of ERISA plan funds to an administrator, who had no enforceable duty or liability to the Plan.[5] The 91% of ERISA plans[6] using such "expert" administrators are argued to be expending funds on entities free to dispose of assets with impunity and immunity. The decision General American requests of this Court would cause great losses to ERISA plans, because these administrators would know that shoddy,

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[5] General American's contention that an "equitable" action "might" be available to allow recovery by the Plan is, under the cases it cites, incorrect, as the funds were not given to a partner of General American's, but a completely outside party.

[6] The claim that such immunity from both contract law and ERISA fiduciary status would help preserve the privacy of employees is 1) insufficient to allow same and 2) incorrect — unless this Court would also find that no employer or plan is allowed to even audit the conduct of third-party administrators. Thus, Plans would not only be forced to make a gift of plan funds to immune administrators, the Plans could not even figure out if such gifts were being given to those who showed their appreciation by giving back decent administration.

substandard, even fraudulent administration was without liability, without even bare contractual responsibility.

General American argues that third-party administrators should be able to count on immunity for wrongful disposition of plan assets to foster the least expensive administrative costs for ERISA plans. Less expensive administration is a very high price indeed for loss of substantial plan assets, such as the $600,000 General American admits it wrongfully disposed of in this matter. As noted by General American, the insurance and claims administration industry performs many ERISA plan functions, precisely because they advertise their expertise in this area. One who obtains administration fees from plan assets on the basis of expert status should not be found to argue, as is done here, that waste of plan assets shall go unremedied because of *in*expert conduct. Having voluntarily chosen to reap the financial rewards of controlling plan assets, an insurer who does so has also voluntarily chosen to take the responsibility of providing the services promised in a fashion that preserves those assets for participants and their beneficiaries, rather than harms those protected by ERISA by diverting the assets of their plans to ineligible persons. Avoidance of wrongful depletion of plan assets is the purpose behind imposition of fiduciary status under ERISA. Waste of same to obtain inexpensive administration is not.

CONCLUSION

The Ninth Circuit did not err in following its own precedent and that of all other circuits in finding that an entity with final binding authority over disposition of plan assets is a fiduciary, especially where that authority admittedly involved the exercise of discretion. The radical new standard urged by Petitioner, across-the-board immunity for those who are paid by ERISA plans for expert administration, is one unsupported by any law or by basic common sense.

DATED: November 20, 1997.

Respectfully submitted,

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IT CORPORATION,
IT CORPORATION BENEFIT PLAN,
and HARRY JOSEPH LUKOWSKI

APPENDIX A

SERVICES TO BE PROVIDED BY THE SERVICE CONTRACTOR

To be attached to and made a part of the agreement by and between

IT CORPORATION
AND
GENERAL AMERICAN LIFE INSURANCE

The services to be performed by the Service Contractor are as set forth in the following pages.

BASIC CLAIMS ADJUDICATION SERVICES

These Basic Services provide for the processing of all claims incurred and received during the contract period. The services to be performed by the Service Contractor are:

1. Preparation of Claim Checks and Explanation of Benefit forms on a universal check form on the bank chosen by the client;
2. Monthly reports of claim payments, including date claim was incurred, date paid, type of claim, amount of charges and amount of payment identified by each covered member;
3. Evaluate evidence of good health of late enrollees;
4. Maintenance of individual benefit records for determination of plan benefits and satisfaction of deductibles;
5. Follow up for additional medical or service information from provider;

6. Coordinate benefit payments with other employee plans;
7. Maintenance of records for determination of overutilization or plan abuse by users and providers;
8. Preparation of annual statistical claim reports for valuation of "Incurred but not Received";
9. Preparation of annual report of benefit payments;
10. Preparation of IRS Reports (1099) Medical Provider Fees;
11. Claim checks and EOB will be returned to Client for distribution; and
12. Claim control practices.

DIRECT CLAIMS AND VERIFICATION

The Direct Claims Services include:

Employee I.D. cards ready for client to transcribe the necessary information;

Verification of employee eligibility as to coverage and benefits. Client is required to supply information concerning changes in employee coverage; and

Claim transmittal envelope for employee to use when filing claims direct with General American Life.

[APPENDIX B EXCLUDED]

APPENDIX C

CLAIMS PROCESSING AND PAYMENT

To be attached to and made a part of the agreement by and between

IT CORPORATION
AND
GENERAL AMERICAN LIFE INSURANCE

The Service Contractor shall accept for processing and payment or denial, all claims presented under the Plan. The examination, investigation, review, calculation, approval and disapproval of all such claims by the Service Contractor shall be in accordance with the Service Contractor's claim cost control standards, audit procedures, and claim practices, as agreed to by the Client.

The Service Contractor shall investigate the validity of each claim and each recurring benefit payment and shall compute the benefits payable, if any, on each such claim.

The Service Contractor shall pay all claims which it has determined to be payable under the Agreement, except the following:

a. All contested or doubtful claims or benefit amounts shall be referred to the Client for its determination of liability and instruction to the Service Contractor. Claims with respect to which there is legal action against the proceeds, such as suit, attachment, or restraining order; on such claims the Service Contractor will consult with the Counsel of the Client and shall proceed to pay or deny the claim or turn the file

over to the Client for further processing, as set forth in written advice from the Client's Counsel.

b. The Service Contractor will take appropriate action, such as denial, holding in pending file, or turning over to the Client if the claim becomes involved in legal action or proceedings; such instances would include but not be limited to where the claimant or his representative has filed a claim or an appeal under any law applicable to benefit entitlement, including but not limited to workmen's compensation, unemployment compensation, disability or cash sickness law of any state.

It is understood that the duties of the Service Contractor under this Agreement shall not involve insurance department proceedings, tax proceedings, proceedings before quasijudicial boards, medical proceedings, the furnishing of legal advice, or participation in any function or activity prohibited to the Service Contractor; provided, however, the Service Contractor will provide to the Client its files and any other records of action that it has taken with respect to any claim.

Subject to and except as otherwise provided in any set of rules of administrative procedure agreed to in writing by the Client and the Service Contractor with respect to the administration of benefits pursuant to this Agreement, each individual administrative act, decision and interpretation by the Service Contractor (including any errors, clerical or otherwise) shall be binding upon the Client with respect to past performance or completed action.

If after any payment has been made hereunder (i) to or on behalf of an ineligible individual, or (ii) it is determined that more or less than the current amount has been paid by the Service Contractor, the Service Contractor will attempt to recover the payment made to an ineligible person, or the overpayment, or will adjust the underpayment, but the Service Contractor will not be required to initiate court proceedings for any such recovery. If the Service Contractor is unsuccessful, the Service Contractor shall so notify the Client in order that the Client may take such action as may be available to it.

Accounting for Claim Payment

During the continuance of the Service Contractor's claims processing and payment of benefits pursuant to this Agreement, the Service Contractor shall render an accounting monthly and yearly unless otherwise agreed upon by the Service Contractor and the Client in writing. Such accounting details may be set forth in a separate written statement, but shall include the following:

a. Monthly Accounting

Within 30 days following the end of a Plan month, the Service Contractor will furnish to the Client a list of claims paid, showing the coverage(s) under which the claim was paid and the amount paid on each claim, the number of claims paid, the totals paid under each coverage, and the grand total of payment for the month.

b. Annual Account

Within sixty (60) days following the end of a plan year or other yearly period specified by

the Client, the Service Contractor shall furnish a summary of all claim transactions during such year, the number and amount of claims by coverage and totals.

c. "Plan month" shall begin with the first calendar day of each month.

"Plan year" — the first Plan year shall begin on December 1, 1987 and end on December 31, 1988. The second Plan year shall begin on January 1, 1989 and successive Plan years shall begin with the anniversary of such date.

(5)

No. 97-520

Supreme Court, U.S.
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IN THE
Supreme Court of the United States
OCTOBER TERM, 1997

GENERAL AMERICAN LIFE INSURANCE COMPANY,
Petitioner,

v.

IT CORPORATION, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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REPLY BRIEF OF PETITIONER

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REPLY BRIEF OF PETITIONER

INTRODUCTION

Petitioner General American Life Insurance Company ("General American") respectfully submits this Reply Brief which addresses four points newly raised by the Brief in Opposition by IT Corporation ("IT Corp.").

As shown below, IT Corp.'s newly raised points simply reconfirm that the Ninth Circuit's decision not only sharply clashes with ERISA[1] and its regulations, but creates far more problems in a key area of ERISA plan administration than it solves. Unless this Court intervenes, the increasingly heavy burden of litigation in this area—15 recent published court of appeals decisions referred to in the petition, with several dozen published district court decisions—will only swell even more due to the conflicts presented by this latest decision. Given the "centrality of pension and welfare plans in the national economy," *Boggs v. Boggs*, 117 S.Ct. 1754, 1758 (1997), it is vital that this Court resolve the pivotal issue of ERISA fiduciary status presented by this case. This issue not only touches every pension and welfare plan in the country, but has caused a vast amount of litigation and created a sharp split now affecting eight of the circuits.

A few introductory words are necessary because the Brief in Opposition, in raising new points including a discussion of an agency relationship, uses some extremely "loose language" in its factual sections. Several brief examples will suffice.

IT Corp. tells the Court that the Administrative Services Agreement ("ASA") between IT Corp. and General American stated the *Plan* was to open a bank account "for General American's use in making payments as Gen-

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[1] ERISA is the acronym for the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001, *et seq.*

eral American *saw fit*. (Appendix to Petition pp. 25a-26a 'Section 2'.)." (Brief in Opposition ("Opp.") at 2) (emphasis added). A look at the citation shows, however, that *IT Corp.* was to open a bank account to be used by General American *"to make payments pursuant to [the ASA] and the Plan."* (emphasis added).

Pursuant to section 5 of the ASA, General American, "acting . . . as agent of [IT Corp.]" (App. to petition at 25a), was to perform certain administrative and ministerial activities including initial claims-processng and the forwarding of payment checks to *IT Corp.* for distribution. (Opp., App. at A1-A2). The Plan established by IT Corp. contained the written verification of eligibility requirements that General American was required to follow. Under the Plan, a late enrollee was excluded from eligibility if "unable to carry on the duties and activities of a person of similar age." (App. to petition at 19a). In case of payment to an ineligible person, the ASA provided that the right to initiate court proceedings lay with *IT Corp.*, not General American. (Opp., App. at A5-A6). IT Corp.'s assertion that the parties agree General American wrongfully disposed of $600,000 in plan assets is not true. (Opp. at 19-20). The issue of fiduciary status was the sole question before the courts below, the amount of payments and the question of whether General American, in paying claims, acted on instructions of IT Corp., were not before the courts below.

Contrary to IT Corp.'s suggestion (Opp. at 3), General American asserts that fiduciary status is related to the plan documents. ERISA not only requires that the allocation of fiduciary responsibility be set forth in the plan in writing, but it forbids a "named" fiduciary from delegating to anyone, other than an investment manager, the authority or discretion to manage or control plan assets.[2]

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[2] Petition at 10, 24; ERISA §§ 402(a)(1), (b)(2), 404(a)(1)(D), 405(c)(1), 29 U.S.C. §§ 1102(a)(1), (b)(2), 1104(a)(1)(D), 1105(c)(1).

ARGUMENT

THE NEW POINTS MADE IN THE BRIEF IN OPPOSITION ARE WITHOUT MERIT

The first point newly raised by IT Corp. involves a contractual provision in the ASA "*binding*" IT Corp. "with respect to past performance or completed action" by its agent, General American. (Opp., App. at A5-A6). IT Corp. contends that this provision somehow makes this case factually "unique" and confers fiduciary status on General American, thus distinguishing the case from the appellate decisions in seven other circuits relied on by General American. (Opp. at 4-5). IT Corp. is simply attempting to draw the Court's attention away from the fact that the Plan's eligibility requirements were laid down by IT Corp. in the Plan and that General American was required to follow those written requirements. The issue of fiduciary status under ERISA turns on who makes the framework of rules to govern plan administration as distinguished from who merely applies these existing rules on a case-by-case basis. IT Corp. made the eligibility rules for participation and benefits under the Plan and General American was required to follow them; accordingly, it did not exercise any "authority or control" over the Plan. Thus, whether a claim was paid or not is irrelevant to the issue of ERISA fiduciary status.

IT Corp.'s argument is misleading and untrue for two separate reasons. First, the Ninth Circuit's decision is not based on the ASA's contractual provision which, as shown below, is merely a recitation of a basic principle of agency law that is inherent in *every* case involving a contract-service provider. Instead, the court decided the case based on erroneous legal holdings that *any* claims-handling work in verifying eligibility for participation or benefits would involve plan interpretation and judgment and thus create fiduciary status, and that any claims agent automatically becomes an ERISA fiduciary whenever it handles plan money or has check-writing authority to pay benefits.

(Petition, App. at 5a to 12a). These holdings are in the sharpest of conflict with ERISA itself and the holdings of all other circuits to have considered these issues.

Second, the ASA's contractual provision merely acknowledges that the *general law of agency* applies to the relationship between the parties:

> . . . each individual administrative act, decision and interpretation by the Service Contractor [General American] (including any errors, clerical or otherwise) shall be binding upon the Client [IT Corp.] with respect to past performance or completed action. (Opp., App. at A5).

This contractual provision between IT Corp. and General American is nothing more than a recital that the law of agency makes the employer-principal bound by the acts of its agent within the scope of its authority or apparent authority. *See* section 140 of the *Restatement (Second) Agency*. IT Corp. was in no different a situation under agency law than had it used one of its own employees to determine eligibility for participation or benefits and to write payment checks. Further, it was in exactly the same position under agency law as the employers in all of the decisions from the other seven circuits which have held that the claims-processing and payment agent is not a fiduciary when it is merely required to follow a framework of rules established by the plan's administrator.

In short, General American's power as an agent to "bind" IT Corp. with respect to "past performance or completed action" was not the basis of the Ninth Circuit's decision; moreover, it is not novel or unique. To the contrary, it is inherent in the principal-agent relationships found in *all* of the decisions by the seven other circuits discussed in the petition at pages 15-20. Each of these decisions holds that ERISA's definition of fiduciary does *not* include agents of the employer or the plan who merely perform initial claims-handling and check-writing services under a framework of rules made by the plan's adminis-

trator. As explained by these decisions, it is not a sign of discretionary authority that the agent allegedly errs and authorizes or pays a claim that should not have been paid;[3] the employer still made the plan's framework of rules and the agent still has "an obligation to follow the written plan instrument."[4] Further, the decisions make clear that the claims agent would be a fiduciary only if it had the " 'ability to make policy decisions *outside* of a preexisting or separate framework of policies, practices and procedures,' "[5] or had the authority to conduct the ERISA review procedure for denied claims.[6]

In its second newly raised point, IT Corp. contends that a contract service-provider is a non-fiduciary only if it *recommends,* as distinguished from making, decisions in the course of plan administration. (Opp. at 6-15). This is not only erroneous but conflicts with the Department of Labor's regulations in 29 C.F.R. § 2509.75-8. The regulations provide an intentionally-broad "safe-harbor" from fiduciary status for claims-processing and payment agents who simply perform 11 wide categories of administrative and ministerial functions under a framework of rules established by the plan's administrator.[7] If IT

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[3] *Geller v. County Line Auto Sales, Inc.*, 86 F.3d 18, 21 (2d Cir. 1996); *Bromenn Healthcare v. Northwestern Nat. Life Ins. Co.*, 806 F.Supp. 799, 801, 804 (C.D. Ill. 1992).

[4] *Confer v. Custom Engineering Co.*, 952 F.2d 34, 39 (3d Cir. 1991).

[5] *Baker v. Big Star Division of the Grand Union Co.*, 893 F.2d 288, 290 (11th Cir. 1989) (emphasis added) (citation omitted).

[6] ERISA § 503, 29 U.S.C. § 1133.

[7] The decisions cited by IT Corp. undercut rather than support its position. For example, *Custer v. Sweeney*, 89 F.3d 1156 (4th Cir. 1996), did not involve claims-processing or payment. The court held that ERISA did not preempt an attorney malpractice action against the plan's attorney who recommend the payment of lavish costs for a private jet and mansion. Significantly, it held that a non-fiduciary does *not* become one by acting negligently. *Santana v. Deluxe Corp.*, 920 F.Supp. 249, 254 (D.Mass. 1996),

Corp. were correct, the Department would have drafted the "safe-harbor" to provide that non-fiduciary functions were limited to "making *recommendations* as to eligibility for participation or benefits," etc. Instead, the regulations specify that large numbers of decision-making functions performed under rules made by the employer are purely administrative and non-fiduciary including "(1) *application* of rules determining eligibility for participation or benefits," "(6) *calculation* of benefits," and "(10) *processing* of claims." (emphasis added). As shown above, it was IT Corp. which established the eligibility rules for participation and benefits; it was IT Corp. which inserted those rules in the Plan document; and it was General American that was required to apply those rules. While the regulations mention "recommendations," they do so *only* as the final function in a list of 11 categories: "(11) Making recommendations to others for decisions with respect to plan administration."

In essence, IT Corp.'s new argument boils down to an absurdity. IT Corp. asserts that a party is a fiduciary if it has "final authority" over the *non-fiduciary* administrative and ministerial functions identified in the "safe-harbor." (Opp. at 6-15). According to IT Corp., "it is final authority that determines whether a function in question is a fiduciary function imposing a fiduciary duty." (*Id.* at 15). IT Corp. is certainly correct in stating that

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held that a third-party administrator was not a fiduciary where it merely processed and paid claims with plan funds based on a framework of rules established by the plan's administrator. The court's reference to "recommendations" dealt only with the agent's power in making "recommendations as to which services would make the plan most cost effective." *Haidle v. Chippenahm Hospital, Inc.*, 855 F.Supp. 127, 132 (E.D.Va. 1994), squarely held that "processing and payment of claims were administrative functions." Similarly, *Libby-Owens-Ford Co. v. Blue Cross & Blue Shield Mutual of Ohio*, 982 F.2d 1035 (6th Cir), *cert. denied*, 510 U.S. 819 (1993), held that the party who had the power to review the appeal of denied claims was an ERISA fiduciary; this was in accord with ERISA § 503, 29 U.S.C. § 1133.

this is the Ninth Circuit's position. The Department of Labor, however, has taken exactly the *opposite* position in the regulations, as do the seven other circuits which have considered the issue. In a key section overlooked by the Ninth Circuit and IT Corp., the regulations carefully explain that where the employer has established the plan's framework of rules, the 11 broad categories of claims-processing and payment functions are "purely ministerial functions" falling *outside* of the fiduciary functions described in ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A):

> Therefore, a person who performs purely minsterial functions such as the types described above . . . within a framework of . . . rules . . . made by other persons is not a fiduciary because such person does not have discretionary authority or discretionary control respecting management of the plan [and] does not exercise any authority or control respecting management or disposition of the assets of the plan . . . (App. to petition at 37a-38a).

In short, both common sense and the ERISA regulations dictate that having "final authority" over an administrative, ministerial, *non-fiduciary* function to be performed under the plan administrator's rules does *not* make a party a fiduciary. While both the Ninth Circuit and IT Corp. succumbed to this fallacy in logic, seven other circuits have wisely come to the correct conclusion.

In its third newly raised point which builds on the false premise contained in the second, IT Corp. asserts that because General American supposedly had "final" authority over initial claims-processing and payment to be performed under the Plan's rules, it was a fiduciary under section D-3 of the "safe-harbor" regulations. (Opp. at 6-9). This statement overlooks the fact that IT Corp. set the rules and inserted them in the Plan; and it is 180 degrees contrary to the position taken by the Department of Labor and the seven other circuits. In D-3 of the regulations, the *only* person identified as a "fiduciary" is

a *plan employee "designate[d]"* by the *plan* as having "the *final authority* to authorize or disallow benefit payments in cases where a *dispute exists as to the interpretation of plan provisions relating to eligibility for benefits.*" 29 C.F.R. § 2509.75-8 (D-3) (emphasis added) (App. to petition at 39a). As confirmed by the claims-handling and review regulations issued two years later,[8] these regulations discussing "final" authority are necessarily referring to the final ERISA review procedure for denied claims under § 503 of ERISA, 29 U.S.C. § 1133. The only dispute over benefit eligibility could be between the plan and its participants, and by statute there could be no "final authority" beyond the fiduciary review procedure under § 503. In this case, the claims review fiduciary with the requisite authority to review denied claims is IT Corp. (Petition at 1-2).

In its fourth newly raised point, IT Corp. contends that whether a contract-service provider is a non-fiduciary should depend on whether, in following the plan administrator's rules, it decides that a particular claim—perhaps one out of thousands processed each day—should be *denied* rather than paid. (Opp. at 17-19). Only if it pays the claim, IT Corp. asserts, is the party a fiduciary because then it is paying claims out of plan assets; if the claim is denied, it is not a fiduciary. (*Id.*)[9] IT Corp. also incorrectly suggests that the bonding regulations indicate that persons who "have control and/or authority over to whom the checks are made payable are fiduciaries."

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[8] 29 C.F.R. § 2560.503-1; petition at 12, 20-21.

[9] *LoPresti v. Terwillinger*, 126 F.3d 34 (2nd Cir. 1997), does not assist IT Corp.'s argument. The case did not involve benefit claims or the "safe-harbor" regulations. The court merely held that the president and major shareholder of an employer became an ERISA fiduciary when he commingled plan assets—moneys deducted from employees' paychecks—with the company's general assets, and then used the plan assets to pay the company's creditors.

(Id. at 17).[10] Under IT Corp.'s hypothesis, a party engaged in initial claims-processing and payment under rules established by the plan's administrator might be a fiduciary one moment when denying a claim; a non-fiduciary the next moment when approving a claim; and—like the Greek sea god Proteus—a half fiduciary, half non-fiduciary, the next moment when approving and denying a claim in part. If IT Corp. were correct, the Department of Labor would have drafted the "safe-harbor" regulations to provide that a party performing administrative and ministerial claims-processing and payment services under plan rules became a fiduciary if it *paid* a claim. Surely a fair warning would have surfaced in the regulations—a harbor buoy at least. IT Corp.'s anomalous construction of the "safe-harbor" converts it to a mine-field—every claims-processing and payment agent required to follow plan rules would be a fiduciary every day whenever it applied those rules and paid a claim.[11]

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[10] The bonding regulations say no such thing. IT Corp. has it exactly backwards. ERISA § 412(a) makes a clear-cut distinction between (1) "[e]very fiduciary of an employee benefit plan" and (2) "every person which handles funds or other property of such a plan" ("plan officials"); the regulations explain that the latter category of *non-fiduciaries includes* "any person with the *power to sign or endorse checks.*" (emphasis added.) 29 C.F.R. § 2580. 412-4 and -6. *Excluded* from the bonding requirements are those persons, referred to by IT Corp., who are "janitors" or who merely put checks into envelopes and mail them. The regulations explain that these people need *not* be bonded because the "checks . . . cannot be negotiated by the persons performing duties with respect to them." *Id.*

[11] Additionally, IT Corp. errs in stating that General American contends it can act with impunity under federal or state law, and that IT Corp. has no recourse against any entity. (Opp. at 19). As set forth in the petition, page 4, note 1, ERISA contains a "written plan instrument" rule which is one of ERISA's "core functional requirements." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995). ERISA requires that plans be in writing, requires that their written terms be enforced, and provides suit

CONCLUSION

For the reasons set forth above and in the petition, petitioner urges the Court to grant certiorari in this case.

Respectfully submitted,

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to enforce the plan's terms. (*Id.*) The ASA contains cross-indemnity provisions (petition at 3, and App. at 27a), and is plainly a "contract, or other instrument under which the plan is . . . operated." ERISA § 104(a)(1), (b)(4). If IT Corp. truly thought that benefits were paid without its approval, it could have sued General American under ERISA as a nonfiduciary for equitable relief to enforce the cross-indemnity provisions which benefit both it and the Plan. Additionally, IT Corp.—not General American—could have sued the medical service providers for repayment. (Opp., App. at A6).